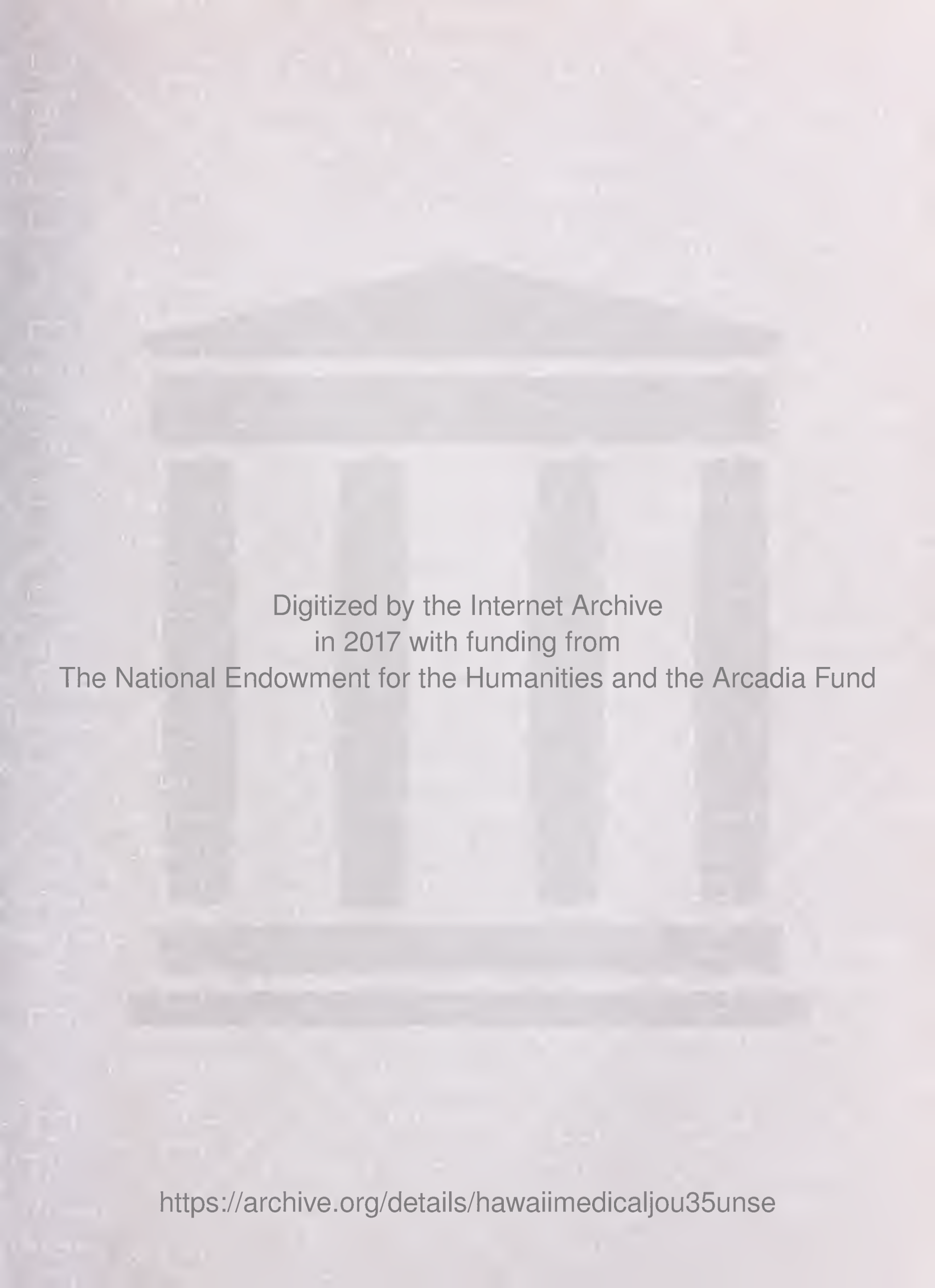

Digitized by the Internet Archive
in 2017 with funding from
The National Endowment for the Humanities and the Arcadia Fund

https://archive.org/details/hawaiimedicaljou35unse

JANUARY, 1976
VOL. 35, NO. 1

Hawaii Medical Journal

CONTENTS

Criteria for Pronouncement of Death and the Human Brain Death Syndrome 11
J. K. Sims, M.D.

The Autopsy: Its Role in Modern Medicine 14
A. G. Scottolini, M.D.

Continuing Medical Education 19

Editorials 18

Hawaii Academy of Family Physicians' Newsletter 22

HMA Newsletter 17

In Memoriam 21

News and Notes 22

The Library SP
Acquisitions Division
University of California, San
Francisco
San Francisco California 94143

LIBRARY
U.C. SAN FRANCISCO
FEB 19 1976

Both often



Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium®
(diazepam) Ⓡ IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley New Jersey 07110

PreSun

(5% PABA LOTION)

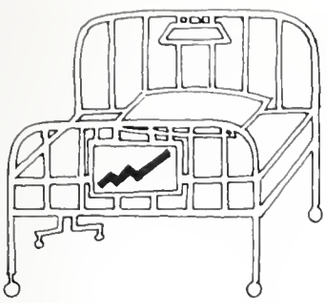
may help prevent harmful effects of the sun such as premature aging of skin and skin cancer.*



*Information on file at Westwood Pharmaceuticals Inc.

WESTWOOD
PHARMACEUTICALS INC.
Buffalo, New York 14213

©1974, W. P. Inc.



Hospital News

Castle Hospital

The Medical/Dental Staff held its quarterly (annual) meeting at the hospital on Friday 24 October at a 12:30 noon luncheon.

New officers were elected, and a new Nominating Committee for 1976 likewise. The 1976 officers are:

Chief of Staff John Pearson M.D.
Vice-chief Bernard Scherman M.D.
Secretary Frank Ceccarelli M.D.

Listed as Active and eligible to vote at the election were 39 active members.

The Medical/Dental Staff has adopted a new By-Law which has also been approved by the governing body. It makes it difficult, from I January on, for a staff member to have more than twelve "patient contacts" a year—admissions, consultations, surgery, or to see a patient in the emergency room—unless he or she is or becomes Active and assumes the responsibilities inherent in such membership. In other words, the *privilege* of using the hospital and its facilities for one's patients is to be tendered only in exchange for active service to the Medical/Dental Staff and the hospital. The *responsibilities* that go with being Active are: To attend meetings, be on the on-call lists, and work on committees.

Recognizing the fact that most practitioners are quite busy inside and outside Castle Hospital, and they might well have important commitments to other hospitals too, the Medical/Dental Staff by-law change allows for exceptions for reasons that must be acceptable to the Medical Executive Committee.

J.I.F.R.

HAWAII MEDICAL JOURNAL

Published Monthly by the
HAWAII MEDICAL ASSOCIATION
(Incorporated in 1856 under the Monarchy)
510 S. Beretania St., Honolulu, Hawaii 96813

EDITORS

Editor, HARRY L. ARNOLD, JR., M.D.
News Editor, HENRY N. YOKOYAMA, M.D.
Assistant Editor, DORIS R. JASINSKI, M.D., M.P.H.
Contributing Editor, ROBERT H. MOSER, M.D.
Contributing Editor, J.I. FREDERICK REPPUN, M.D.
Book Review Editor, WINFRED Y. LEE, M.D.
Executive Editor, PAUL STEWARD

OFFICERS

President, WILLIAM W.L. DANG, M.D.
President-Elect, CALVIN C.J. SIA, M.D.
Past President, WINFRED Y. LEE, M.D.
Secretary, R. VARIAN SLOAN, M.D.
Treasurer, GROVER H. BATTEN, M.D.

County Presidents

Hawaii, KENNETH HUGHES, M.D.
Honolulu, DOUGLAS B. BELL, II, M.D.
Kauai RIEAZI REMITIO, M.D.
Maui, CLIFFORD MORAN, M.D.
Delegate to AMA, GEORGE H. MILLS, M.D.
Alternate Delegate to AMA,
HERBERT Y.H. CHINN, M.D.

Advertising Representatives
National:
HAWAII MEDICAL ASSOCIATION
510 S. BERETANIA STREET
Honolulu, Hawaii 96813
Phone (808)536-7702
Honolulu:
LILITH JURRY, Phone 946-0053

THE JOURNAL may not be held responsible for opinions expressed in papers, discussions, communications, or advertisements. The advertising policy of the HAWAII MEDICAL JOURNAL is governed by the rules of the Council on Drugs of the American Medical Association. The right is reserved to reject material submitted for editorial or advertising columns. All material for publication must be in the hands of the editor on or before the 10th day of the month preceding publication date. Reprints of original articles will be supplied at actual cost. A reasonable number of illustrations accompanying an article will be accepted for printing. The right is reserved to ask the author to bear cost of these when it is found necessary to do so.

Copyright, 1976 by the Hawaii Medical Association, Honolulu, Hawaii. 2nd class postage paid at Honolulu, Hawaii. Office of Publication: Mabel L. Smyth Memorial Building, 510 S. Beretania St., Honolulu, Hawaii 96813.

324773

THE NATURAL WAY

For more than thirty years PREMARIN (Conjugated Estrogens Tablets, U.S.P.) has been prepared with natural equine estrogens exclusively—without synthetic estrogen supplements. For more than thirty years it has provided the complete estrogen complex in the proportions found in its natural source. And for more than thirty years PREMARIN has enjoyed an unparalleled record of clinical efficacy and acceptance.

PREMARIN. The only estrogen preparation available that contains natural estrogens exclusively and also meets all U.S.P. specifications for conjugated estrogens. Assurance of quality for you and your patients.

PREMARIN . . . naturally.

BRIEF SUMMARY
(For full prescribing information, see package circular.)
PREMARIN®
(Conjugated Estrogens Tablets, U.S.P.)

Indications: Based on a review of PREMARIN Tablets by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications for use as follows:
Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus.
"Probably" effective: For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are contraindicated in patients with (1) markedly impaired liver function; (2) known or suspected carcinoma of the breast, except those cases of progressing disease not amenable to surgery or irradiation occurring in women who are at least 5 years postmenopausal; (3) known or suspected estrogen-dependent neoplasia, such as carcinoma of the endometrium; (4) thromboembolic disorders, thrombophlebitis, cerebral embolism, or in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding.
Warnings: Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.

The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.
Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.
Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:
nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating
breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)
breast tenderness and enlargement
reactivation of endometriosis
possible diminution of lactation when given immediately postpartum
loss of libido and gynecomastia in males
edema
aggravation of migraine headaches
change in body weight (increase, decrease)
headache
allergic rash
hepatic cutaneous porphyria becoming manifest
Dosage and Administration: PREMARIN should be administered cyclically (3 weeks of daily estrogen and 1 week off) for all indications except selected cases of carcinoma and prevention of postpartum breast engorgement.

Menopausal Syndrome—1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.

Postmenopause—as a protective measure against estrogen deficiency-induced degenerative changes (*e.g.* osteoporosis, atrophic vaginitis, kraurosis vulvae)—0.3 mg. to 1.25 mg. daily and cyclically. Adjust dosage to lowest effective level.

Osteoporosis (to retard progression)—usual dosage 1.25 mg. daily and cyclically.

Senile Vaginitis, Kraurosis Vulvae with or without Pruritus—0.3 mg. to 1.25 mg. or more daily, depending upon the tissue response of the individual patient. Administer cyclically.
How Supplied: PREMARIN (Conjugated Estrogens Tablets, U.S.P.)

No. 865—Each *purple* tablet contains 2.5 mg., in bottles of 100 and 1,000.

No. 866—Each *yellow* tablet contains 1.25 mg., in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 867—Each *red* tablet contains 0.625 mg., in bottles of 100 and 1,000.

No. 868—Each *green* tablet contains 0.3 mg., in bottles of 100 and 1,000. **7352**

PREMARIN®

BRAND OF

CONJUGATED ESTROGENS TABLETS, U.S.P.

CONTAINS ONLY NATURAL ESTROGENS ...NO SYNTHETICS OR SUPPLEMENTS

Ayerst

AYERST LABORATORIES
New York, N.Y. 10017

Opinion & Dialogue

Should a specially prepared package insert be made available to patients?



Dr. Alexander M. Schmidt
Commissioner,
Food and Drug
Administration



Dr. James H. Sammons
Executive Vice President
of the American
Medical Association

The idea of a so-called patient package insert has been around for a long time. Many physicians already use written instruction sheets to provide patients with information about the drugs they are taking. And some physicians give verbal instructions; but in too many instances these are what I call eye-glazing exercises. I have seen patients sit with glazed eyes listening to a rapid-fire lecture by a hurried physician who has 20 people out in his waiting room. These patients aren't given sufficient understanding and therefore do not follow instructions. So I think the idea of an official package insert for patients is a good one. Perhaps we should really think of this kind of information simply as an extension of drug labeling.

The benefits of patient involvement

Many physicians may not realize how frequently a patient obtains his drug information from Aunt Tillie or the next door neighbor. And this information is almost always bad or irrelevant to the case at hand. Furthermore, the incentive to go along with a prescribed program is slim if the only reading matter the patient receives, along with his prescription, is a bill.

As an educator I am impressed by the principle that the best way to get someone to do something is to involve him in the process. So the

I think there are advantages as well as some real disadvantages in a patient package insert. When you begin to use semi-medical or medical terms to describe complications or possible sequelae of disease or treatment, you may frighten the patient—particularly since the more highly sophisticated patient is not the one who is going to read the insert. The patient who will read it is the one most susceptible to fright and confusion by the language.

On the positive side, a package insert will probably give the patient better insight into why he is being treated the way he is, and it may give the physician a little bit more time. But it does not remove from the physician the need or obligation to explain the insert.

Some pitfalls in the inclusion of side effects

Certainly a patient should be warned of the possibility of serious side reactions—to know what the real dangers are. But it doesn't do a bit of good to indicate that a patient on oral penicillin may develop a rash, itching, or a drop in blood pressure. Or that he may faint. I think the real danger is that fright engendered by the insert may possibly outweigh the potential good.

main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

Only the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebothrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose a special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a patient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005



Kefzol®
cefazolin sodium

Ampoules, equivalent to 250 mg., 500 mg., 1 Gm., and 10 Gm. of cefazolin



Lilly

Additional information available to the profession on request.

Eli Lilly and Company
Indianapolis, Indiana 46206

600062

Criteria for Pronouncement of Death and the Human Brain Death Syndrome

J. K. SIMS, M.D., *Honolulu*

• *As better techniques for resuscitation, intravenous alimentation, pharmacologic anti-arrhythmic intervention, and continuous respirator therapy were applied in clinical medicine during the past decade, a new patient syndrome developed which is now entitled the "human brain death syndrome." This entity has been described in the past under a number of aliases including "brain death,"* [1-2] *"deanimation,"*[3] *"cortical death,"*[4] *"hypoxemic panencephalopathy,"*[5] *"respirator brain,"* [6-7] *"neurologic death,"*[8] *and "irreversible coma."*[9] *The designation "respirator brain" characterizes one of the most important aspects of the human brain death syndrome–the patient does not spontaneously breathe and is entirely dependent on continuous external respirator support.*

The human brain death syndrome is so named since that is what it represents—signs in the patient that reflect the *death of the brain* (functionally, biochemically, physiologically, and anatomically) while the remainder of the patient is still alive. For the brain death patient the heart still beats, blood pressure is maintained (although it may be unstable and require pharmacologic and intravenous fluid support), incisions heal, urine output continues (unless disease prohibits urine production), hair keeps growing . . . only the brain (and parts of the spinal cord) are dead.

The physician keeps the brain death patient "alive" with a respirator (primarily), intravenous alimentation, medications, and supportive nursing care. While these brain death patients are being "kept alive," the brain progresses from multiple foci of dead neurons to eventual liquefaction of the entire brain and major portions of the spinal cord. [6,7,10-13] This liquifying putrefication of the central nervous system takes place over the days, weeks, or months that the patient is artificially supported.

Multiple Dilemmas

The dilemmas that resulted for physicians have been multiple in nature. First came the disheartening realization that, despite the provision of the best medical and nursing care, these patients did not awaken from their irreversible coma—brain death is a form of irreversible coma. Second, the physician had to allay the chronic anxiety of the patient's friends and relatives (physicians, friends, and relatives were all asking after a while, "When will the patient die?"). Third was the consideration of what to do with an irreversibly comatose brain death patient who was chronically occupying an expensive hospital bed while being continuously dependent on respirators, intravenous alimentation, medications, nursing care, and monitoring devices. Fourth, the hospital and the physicians had to decide who was to pay the high costs of maintaining the respirator brain death case—the patient's family, the hospital, or society. Fifth was the ethical question of whether the discontinuation of the respirator was an example of the physician "playing God." For some reason, when the fifth dilemma was argued, the argument was rarely voiced that the physician might be "playing God" whenever he pronounced a person dead using the traditional criteria of death of permanent cardiocirculorespiratory arrest.

These dilemmas were squarely faced by the medical, legal, and theological members of the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death. The committee's Definition of Irreversible Coma was published in 1968[9] and became a landmark in medicolegal history (the theological implica-

This article was partially supported by grant funds from the Department of Health, Education and Welfare, under Public Law 93-154.

*Training Coordinator, Emergency Medical Services Program, 1301 Punchbowl Street, Honolulu, Hawaii, 96813; member, American College of Emergency Physicians; formerly Associate (1971-1972), Center for the Study of Brain Death, School of Medicine, University of California - San Diego (Project Director Dr. R. G. Bickford).

This article reflects *only* the opinion of the author and *does not* necessarily reflect the opinion of the American College of Emergency Physicians, the Hawaii Medical Association, the Emergency Medical Services Program, the National Institute of Neurological Diseases and Stroke (NINDS), the Department of Health, Education and Welfare, or the City and County of Honolulu.

Accepted for publication March 26, 1975.

tions are still not well understood). That committee took into account the medical and legal literature available up to that time, and added the wealth of experience of the committee members for the formulation of that definition.

This landmark Definition of Irreversible Coma was rapidly utilized in many countries because it: (I) required careful serial neurological examinations, (II) included a reasonable conservative duration for the evaluation period (24 hours), (III) insisted on both brain and spinal cord death (ie, death of the central nervous system), (IV) incorporated quantitative electrophysiological measurement of brain function (eg—the electroencephalogram or EEG), and (V) protected the patient from premature discontinuation from the respirator by (I) - (IV) above and by requiring the physician to rule out concurrent sedative/anesthetic overdose or hypothermia.[9]

After the publication of the Definition of Irreversible Coma, neuroscientists and clinicians the world over scientifically evaluated coma patients and brain death patients to see if any refinements of the definition were needed and to further investigate the causes and nature of brain death. Retrospective and prospective studies were made, including a retrospective evaluation of 2,650 brain death electroencephalograms.[14] Also to be investigated were methods of intervention to prevent or minimize patients from progressing into brain death. With better definitions of brain death would come studies on patients who were in "irreversible coma" but whose entire brain was not dead.[15-17]

World Wide Interest

Based on these studies (over 235 medical articles on the brain death syndrome have appeared in the world literature since June, 1971) revisions have been proposed for the 1968 Harvard criteria. These revisions have their importance in the fact that we now are talking about death by definition. The definition of death by criteria has profound implications, since a brain death patient can medicolegally be pronounced dead (brain death) and subsequently be certified as available for organ donation (eg kidneys, hearts, corneas, and other organs), discontinuation of the respirator (to allow "traditional death"—cardiocirculorespiratory death—to take place), and medical research.[18]

The Honolulu Advertiser has publicized Dr. William J. Curran's statuatory "definition of death" proposal in its article "States Urged to Link Death to Brain Activity"[19] (Dr. Curran was the primary legal representative of the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death). Dr. Curran is encouraging the state governments of each state to revise or adopt statutes wherein death is defined as a permanent cessation of brain function rather than as a permanent cessation of cardiocirculorespiratory function ("traditional death"). A proposal for Hawaii to consider is to define death according to Figures 1 and 2. Death, then, could be defined according to cardiocirculopulmonary criteria or brain death criteria.

FIG. 1—*Minimal Neurological Evaluation For The Human Brain Death Syndrome*

(1) No blood or urine sedative/anesthetic/hypnotic/neuromuscular blocker drug levels

(2) No body temperature recorded below 90° F

(3) Absent spontaneous respirations with no concurrent respiratory alkalosis (pH should be in the range 7.38 to 7.42 and the pCO_2 should be in the range 35 to 45 mm Hg)

(4) Absence Cranial Nerve Functions: (a) no pupillary response to bright light, (b) no oculovestibular reflex. . .nor otic ice-water caloric induced eye movements, (c) no corneal reflexes, (d) no gag response to tracheal suctioning, (e) no head movements to noxious stimulation of face

(5) No decerebration/decortication/opisthotonus (spontaneous or inducible)

(6) EEG electrocerebral silence (ie, EEG isoelectricity) as strictly defined (with 30 min. recording per session)

(7) 1 through 6 above for 24 hours or more (see text)

No longer considered necessary are:

(a) pupillary dilation (ie, mydriasis)[22,27,45]

(b) absence of spinal cord (deep tendon) reflexes[15,22-28,45]

(c) absence of superficial reflexes[15,22-28,45]

(d) absence of response to noxious stimuli applied below the head (ie, applied to the trunk or in the extremities)[15,22-28,45]

FIG. 2—*Evaluation for Cardiovasculorespiratory Death or "Traditional Death"*

ABSENCE OF:

(1) blood pressure
(2) pulse
(3) heart sounds
(4) respirations
(5) pupillary response to bright light
(6) electrocardiograph (EKG) activity

(1) to (6) above for 15-210 minutes[47-49]

Evaluation for the presence or absence of spontaneous respirations is the first step in the examination of any patient under consideration for the diagnosis of the human brain death syndrome (BDS). Any form of spontaneous respiratory activity, no matter how minute, is grounds for automatic exclusion of the patient from the BDS category, by definition.

During each evaluation for respiratory activity, the arterial blood gas PaO_2,$PaCO_2$, and pH must be within normal limits. The pH must not be above 7.45 and the $PaCO_2$ must not be less than 35 torr (35 mmHg), since profound respiratory alkalosis results in apnea. This cessation of breathing as seen in severe respiratory alkalosis is termed "post-hyperventilation

apnea."[20-21] Because of the phenomenon of post-hyperventilation apnea, the hyperventilation of the brain death candidate (with room air or any higher percentage of oxygen mixture) is contraindicated prior to taking the patient off the respirator to evaluate for respiratory activity in this brain death candidate.

In contrasting the remainder of the "Harvard Criteria" of 1968 with the criteria for brain death of 1975 (Figure 1), the emphasis is now shifted to brain death and away from central nervous system (brain and spinal cord) death. As has been pointed out [15,22-28] it doesn't particularly matter to the patient what the status of his spinal cord is if his brain is dead. Brain death criteria now emphasize cranial nerve evaluations and de-emphasize peripheral spinal-cord-mediated reflexes and responses.[15,22-28,45]

EEG Criteria

The emphasis on the death of the brain is also seen in the strict electroencephalographic (EEG) criteria that must be met for a composite establishment of the diagnosis of the human brain death syndrome.[7,9,14,22,23,28-30] EEG machines (electroencephalographs) must be inspected before every recording as to pen alignment, amplifier noise, and calibration specifics to eliminate EEG recording artifacts.

The EEG recordings are generally made with electrodes placed on or into the scalp. The major patient cephalic artifacts in the EEG have already been investigated and should be specifically accounted for in the EEG tracing, including those from the electrocardiogram (EKG),[31] the electroretinogram (ERG),[32-34] the respirator,[35] and the electromyogram (EMG).[36] In addition, continuous digital and analog computer monitoring of the EEG during electrocerebral silence (EEG) isoelectricity has been accomplished.[22,23,33,37-42] Depth electrode EEG recording has also been effected for limited numbers of BDS patients.[43]

In addition to serial neurological examinations and electroencephalograms in evaluating for BDS is the strict requirement for ruling out two concurrent factors: (a) sedative/hypnotic/anesthetic/neuromuscular blocker drug overdose and (b) hypothermia.[9,14,44] Both (a) and (b) can cause a condition very similar to that found in the human brain death syndrome. Both are frequently reversible so a patient with either is very potentially salvageable. Toxicology screens (urine, blood) and warming (electric warming blanket) of the patient are to be done to rule out a reversible condition before placing a patient on a BDS evaluation protocol.

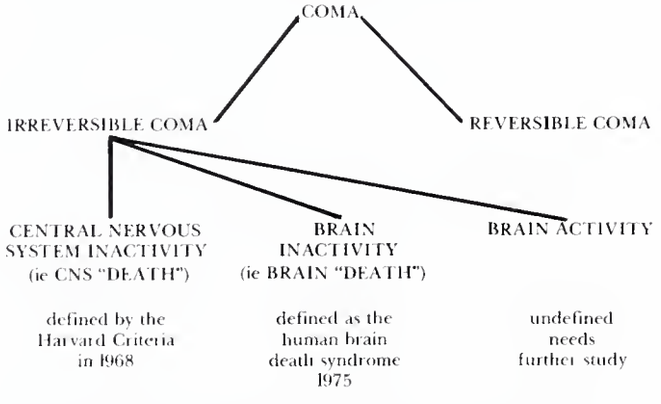
If these respective procedures are negative (ie no sedative/hypnotic/anesthetic/neuromuscular blocker drug levels are detectable or warming the patient to a body temperature above 90° F does not reverse the coma) then, and only then, may the patient be entered in the BDS protocol. Every BDS patient has to have a written record of body temperatures and toxicology results on his hospital chart before the terminal phase of the BDS evaluation.

Evaluation Period

Still not well established is the duration of the evaluation period for BDS patients. Twenty-four hours of continual brain death evaluation (by protocol) is required in several states; however it would appear that a 6 or 12-hour evaluating period might be acceptable.[45] The toxicology evaluation might well turn out to be the time-limiting factor. The patient must meet all criteria before being started on this 24-hour evaluation period. A 24-hour evaluation appears to be more than a sufficient time to evaluate the patient for BDS and not err in the final decision, provided a strict protocol is followed.

The overall direction that the "reversible comas" and the "irreversible comas" are headed is shown in Figure 3. Much research remains to be done on the patients who are in "irreversible coma" but who are not in complete brain death[15-17,46] (such as those patients with coma vigil, massic global strokes, severe permanent anoxic encephalopathy, severe brain gunshot wounds, etc.). A number of these irreversibly-comatose non-brain-death patients have spontaneous respirations and would therefore certainly not be classified as having the human brain death syndrome. The term "irreversible coma" is NOT synonymous with the "human brain death

FIG. 3—*Subdivisions of Coma*



syndrome." The BDS is a subset of the set, "irreversible comas."

Legislation that can be adopted to protect physicians and patients alike should include the following:

(I) Adoption of two criteria for death:
 (A) the human brain death syndrome
 or
 (B) cardiovasculorespiratory death ("traditional death")

(II) Definition of the human brain death Syndrome and cardiovasculorespiratory death as per the strict criteria listed in Figure 1 and Figure 2 in this article.

(III) A requirement that all dead persons have either a brain death checklist or a cardiovasculorespiratory death checklist as a part of the death certificate prior to the signing of the death certificate.

(IV) A requirement that every hospital review monthly all in-hospital deaths and all transient cardiovasculopulmonary arrests (excluding the intentional temporary cardiac, circulatory, and respiratory arrests employed in the operating room for surgery).

(V) A requirement that every hospital submit monthly written reports on the cases in (IV) above to a designated central health agency for that agency to review.

The above (I) - (V) points are suggested to protect physicians, hospitals, autopsy pathologists, coroners, medical examiners, and the patients. The above would help to protect a patient from premature pronouncement or certification of death. The above also creates the possibility of pronouncement of death by telemetry[39] for both the human brain death syndrome and cardiovasculorespiratory death ("traditional death").

In concluding, it should be pointed out that the human brain death syndrome has been studied much more thoroughly scientifically than the traditional cardiovasculorespiratory death in man. Traditional cardiovasculorespiratory death in man needs to be carefully researched to refine 15 - 210 minute (1/4 - 3-1/2 hour) resuscitation interval (as found in Figure 2).[47-49] The results of such a study would greatly assist physicians in deciding on how long to persevere in resuscitation efforts.

Acknowledgements

The author would like to thank Livingston M. F. Wong, M.D. (Director, Emergency Medical Services Program of Hawaii) for reading through the manuscript; Mrs. Terri Bodnar for typing the manuscripts and the figures; Dr. R. G. Bickford for providing highly-motivating intellectual stimuli for the author to investigate this crucial area; the Department of Health, Education, and Welfare for faithful funding of the Emergency Medical Services Program of Hawaii, and the staff of the Hawaii Medical Library for assistance in literature review.

REFERENCES

References will appear in the author's reprints only.

The Autopsy: Its Role in Modern Medicine

A. G. SCOTTOLINI, M.D., *Honolulu*

● *The autopsy from its inception to the present day has played an important role in medical education and research. Under the aegis of the AMA and the JCAH it was utilized effectively to assess and maintain the quality of medical care from 1928 to 1973. The elimination of a minimal autopsy rate for hospital accreditation by the JCAH in 1973 has resulted in further eclipsing of the role of the autopsy in modern medicine. This and other factors are responsible for a decline in an era when the autopsy should be of even greater value in the quality assessment of medical care, namely, with the advent of medical auditing and the PSRO. A proposal is offered in order to deal with the economic and legal realities of the situation with the hope of preserving this time honored and tested technique.*

The history of the autopsy has been a long and fascinating one—beginning with Giovanni Batista Morgagni (1682-1771), who founded the science of pathology in Bologna at the beginning of the 18th Century.

The full concept of the role of the autopsy was not realized until approximately the midportion

Chief of Pathology and Director of Laboratories, Kaiser Foundation Hospital, Honolulu, Hawaii 96815.

Accepted for Publication May, 1975.

of the 19th century when Carl Rokitansky (1804-1878) founded the Vienna school of pathological anatomy and became professor of the first organized department of pathology at the University of Vienna medical school. Further strides were made under one of the greatest figures in the history of medicine, namely, Rudolph Virchow (1821-1902), the father of modern cellular pathology.[2] Through his teaching at the autopsy table and the microscope, pathology became a major pursuit in the study of medicine. Thousands of autopsies were performed during the lives of these great men and by generations of pathologists who followed them.

Beginning in 1928 the AMA set accreditation standards for teaching hospitals. One of these was a 10% autopsy rate. In 1930 this was increased to 15%. This criterion remained in effect for over 30 years until 1966 when these standards were modified. The Joint Commission on Accreditation of Hospitals ruled that the autopsy rate should be 20% for non-teaching hospitals and 25% for teaching hospitals.

In 1973, there was abandonment of this policy, and the requirement of a minimum autopsy rate for accreditation was abolished. Immediate cries of anguish arose from most university centers, along with sighs of relief from most community hospitals.

What was the reason for this about-face on the part of JCAH? The decision of the JCAH to end its requirement of minimum autopsy rates for hospital accreditation was reached apparently because they could not settle on a minimum rate higher than 20% that was applicable to all hospitals. The figure had to be higher than 20% because practically every state in the union had adopted the old JCAH minimum of 20 % for purposes of licensure.

Since the members could not agree, the JCAH elected to end a minimum autopsy rate requirement altogether. It now requires that: (1) adequate necropsy facilities be available, and (2) each clinical major service report its necropsy rate at the time of the JCAH survey.[2,3]

Since 1973 there has been a rapid decline in the autopsy rates of most hospitals. Actually, if one scrutinizes the autopsy rates of most hospitals, it is evident that the decline began before this decision was made.

Why the Decline?

Why has there been a decline in the autopsy rate? From the clinician's perspective there has been a definite decrease in interest in autopsies as a result of: (1) better diagnostic techniques, hence fewer deaths from unknown causes; (2) less emphasis in medical school and specialty training on anatomical pathology in general, with more emphasis on pathophysiology and molecular biology; (3) poor communication between pathologists and clinicians; (4) a fear of liability; (5) poor, dull protocols with too often the cause of death being undiscovered, and (6) the observation that pathologists sometimes perform autopsies begrudgingly.[2,3]

From the pathologist's point of view the observations are made that: 1) there is no area in the laboratory that is more demanding of his time and energy than the performance of an autopsy and yet produces no income; 2) in the order of priorities during the course of a busy day, the autopsy is a burden in addition to the demands of surgical and clinical pathology—necessitating many after-hours of uncompensated time to complete cases; 3) clinicians are no longer interested in attending autopsy rounds—deriving professional gratification merely from the knowledge that they are keeping the pathologist busy, and 4) inadequate facilities, equipment and personnel needs have a low priority in the eyes of most hospital administrators and medical staffs.

In view of the above developments and attitudes, is the autopsy dead? Do we still need it? I am convinced that we do—now more than ever, not only because of old established reasons, but as a consequence of more recent developments in medicine.

The autopsy service should be goal oriented. Those goals are essentially: (1) education, (2) research, and (3) quality assessment of medical care.[3,4,5]

The role of the autopsy in medical education has long been a fact of life for medical students, house staff, and attending staff. However, there has been some lag in the application of newer laboratory techniques to the autopsy, namely, electron microscopy, immunofluorescent microscopy, histochemical stains, and even frozen sections. The opportunity to employ each autopsy examination as a mini-CPC has gone virtually unexploited because of a frequent lack of visual aids and space.

While the pathology amphitheater may be an outmoded luxury that few hospital morgues can afford, certainly the TV camera could be used as purposefully there as in the surgical suite. Unfortunately, tomes of valuable clinical and pathologic material go unused—indeed, long forgotten—because of a lack of an adequate data retrieval system, which is indispensable for worthwhile educational conferences.

The research applications of the autopsy examination are obvious and need no elaboration. While it is conceded that the level of research in anatomical pathology is on a more sophisticated level today than 50 years ago, there are still areas in clinical investigation where good clinical-pathologic correlation is absolutely essential.[5,6,7,8]

Auditing Medical Care

Of increasing importance is the role of the autopsy in the quality assessment of medical care, that is, the auditing of medical care. The autopsy has been and still is one of the major modalities for the detection of errors in diagnosis and therapy.

Some of these errors are of purely academic interest, while others are matters of life and death. Bauer and Robbin's review of 2734 autopsies indicated that there were serious clinical errors in 40% of them.[9] All autopsies that reveal mistakes, whether purely academic or serious, are of importance in sharpening clinical acumen.

Perhaps, as a real measure of quality control—assuming we can get a certain parasitic element of the legal profession off our backs—we should be required to regularly report these errors in the form of a committee report to the JCAH. However, this approach would most certainly require a minimum autopsy rate as well as a minimum total number of autopsies. The New York State Medical Society recommends that a formula for determinig these criteria be related to the total numbers of interns, residents, and fellows in training at an approved hospital.[10]

The growing popularity of the problem-oriented record increases the need for a careful autopsy assessment of clinical diagnosis and therapy.

Under the aegis of quality control, then, autopsy examination of all deaths is justifiable and virtually mandatory.[11] If we accept this premise, it is obvious the cost of medical care will increase because of increased equipment, supply, and personnel needs. Are we willing to devote more technician and pathologist time to the performance of autopsies? Can we afford to designate a pathologist solely for autopsy service?

The average autopsy today costs approximately $400, necessitating 12 hours of the pathologist's time, 6 hours of the pathology assistant's time, and 3 hours of the histotechnician's time. Even at this price many autopsies are done superficially without the benefit of expensive toxicological, bacteriological and viral studies. Occasionally, even animal experiments are indicated.

Who would pay for this idealized autopsy service? The answer is the consumer, of course. It is part of the overall quality control program that safeguards his medical care system. After all, who pays for all the safety devices the consumer demands on his car? Medical insurance could also cover the cost of autopsies.[10] This coverage would be part of an overall national health insurance plan. Legal consent for autopsy would be implied, as in most countries in Europe, unless there were some legally acceptable objection.

However, until adequate legal safeguards are enacted to protect institutions and individuals from avaricious attorneys, objective adjudication systems are established to review alleged errors, and finally, the public is willing to pay the price of its quality assurance program, I, as a practicing pathologist and director of laboratories, am compelled by the economic realities of our existing situation to establish certain priorities and decision-making criteria: (1) Where there are physical limitations as to time, space, and personnel, services for living patients take precedence over those for dead ones; (2) The value of an autopsy, and therefore the decision to perform it, can only be measured in terms of its contribution to a) the clarification of a diagnosis, b) clarification of complications of management, c) training of medical and paramedical personnel, and d) medical progress and knowledge.

REFERENCES

1. Neal MP: The Autopsy: A service and a Teaching Discipline. South Med J, 63:47, 1970
2. Hasson J, Gross H: The Autopsy and Quality Assessment of Medical Care. (Editorial) *Am J Med,* 56:137, Feb., 1974.
3. Jeppson David H: Strengthening the Autopsy Program. *Hospital Topics* 48:31, May, 1970.
4. Edwards JE: The Autopsy: Do We Still Need It? (Editorial) *Chest* 57:113, Feb., 1970.
5. Angrist AA: Plea for Realistic Support for the Autopsy in the Changing Medical Setting. *Bull N.Y Med,* 47:758, July, 1971.
6. Hirsch CS: The Format of the Medicolegal Autopsy Protocol. *Am J. Clin Path,* 55:407, April, 1971.
7. Berry FB: The Autopsy is Dead. (Editorial). *Med Times* 101:17, April, 1973.
8. Gambino SR: The Autopsy—An Essential Component of Clinical Pathology. *Med Lab Observer,* Dec., 1974, p 117.
9. Bauer FW, Robbins SL: An Autopsy Study of Cancer Patients. I Accuracy of the Clinical Diagnoses (1955 to 1965, Boston City Hospital). JAMA 221:1471, 1972.
10. Prutting J: Abolition of Percentage Requirement for Accreditation of Hospitals. (Editorial) *NY State J Med,* Oct. 15, 1972, p 2507.
11. Hasson J: The Autopsy—The Key to Quality Control in Medical Care. (Editorial) *NY State J Med,* Oct. 15, 1972, p 2509.



H. Tom Thorson

Malpractice Insurance problems continue. Argonaut will continue to write policies and renew after January 1, 1976. No assurance can be given relative to the probable duration of their activity.

Hearings were held on January 6, 7, and 8, with the advisory committee reporting to the legislators and the public on their recommendations for legislative action. A broad scope of items was included covering twelve designated areas; 1. Recovery System; 2. Contingent Fees; 3. Definition of Malpractice; 4. Periodic Payments; 5. Statute of Limitations; 6. Collateral Source Rule; 7. Legal Doctrines (Informed Consent; Res Ipsa Loquitur; Ad Damnum); 8. Insurance System; 9. Arbitration; 10. Review (screening) Panels; 11. Board of Medical Examiners; 12. Doctor-Patient Relationship. Material has been sent to all members covering HMA positions. It is hoped that the draft of the actual legislative proposals will be available before the legislature convenes. The proposal will be in an omnibus bill submitted as an administrative measure, but it will be necessary that strong support for the legislation be mustered if major objectives are to be reached.

Mutual Company—A letter of intent has been filed to negotiate a management agreement. The letter of intent authorizes a feasibility study to be made to determine whether or not it is practical for a mutual company to undertake to write malpractice insurance in Hawaii, the company to be a joint venture between the Hospital Association and HMA.

Building News—HMA bought a building. The building is the 320 Ward Avenue Building, now occupied by the Blackfield Hawaii Corp. Title changed hands effective January 1, 1976, although Blackfield will continue to occupy the space until August, 1976, paying rental to HMA during that period. There are a number of other tenants in the building with varying length of leases. Preliminary surveys of the building and its internal arrangement indicate that little remodeling will be necessary for HMA to make effective use of the space available. Studies are continuing to develop the maximum effective occupancy.

HMA Membership Reaches 1000—It is believed that the membership of HMA as counted by the AMA will pass the 1000 mark by December 31, 1975, and qualify HMA for one additional delegate. The final count is still in some doubt but the AMA had a count of 998 on December 29, with about five new memberships in the mail before that date. This represents a substantial growth in membership.

County Visits—President Bill Dang is planning an early visit to each county this year to present the most pressing issues to the membership.

Zero Measles—Through December 11, 1975, 12 serologically proven cases of rubella have been reported. The DOH has a role in epidemic control but the primary prevention is the responsibility of the private physician. The DOH would like to eliminate the disease from Hawaii and urges physicians to be on the alert, particularly those caring for expectant mothers and to report suspected cases by telephone if possible so that early steps can be taken.

Medicare and Medicaid amendments are in the offing. Under present preparation are amendments to titles XVIII and XIX that will further regulate physicians fees. It is proposed that title XVIII (Medicaid) payments be 80% of title XIX (Medicare). When it is realized that Medicare payments are based on the 75th percentile computed on very unrealistic economic indices, it would seem that there will be fewer rather than more physicians willing to accept such patients. We will keep you informed.

The Dang Plan

What it is–A plan to provide the HMA with working capital through loans from the membership.

What it does–Establishes a potential source of capital funds to carry out long range planning in the amount of approximately one million dollars.

How it works–Each member in practice more than one year will loan HMA one thousand dol-

lars over a period of ten years. This may be done by payment of ten dollars per month for ten months each year for ten years, or by early payment of the total with a discount, or by payment of the balance at any time, with discount. Upon the retirement of a member or the separation of a member from HMA, the amount loaned will be refunded without interest. Complete details will be sent to each member with the various options explained.

Job Opening—Armed Forces Entrance and Examining Station desires a Medical Officer (General Practice) for its Honolulu station. Six hours per day Monday through Friday at a salary of $21,262.80 per annum. Call Mrs. Myrna Fong at Fort Shafter - 438-9227.

Workshop for Physicians—HMA, Honolulu County Medical Society and Bureau of Medical Economics are sponsoring a half-day workshop on FINANCIAL CONTROL OF YOUR MEDICAL PRACTICE for physicians only on Tuesday afternoon, March 2, 1976 from 1 p.m. to 5:30 p.m. at Mable Smyth Memorial Building. The workshop will be presented by Conomikes Associates, a nationally recognized medical practice management consultant firm, which conducts continuing education programs for practicing physicians throughout the United States. Enrollment is limited to 35 physicians per session. Enrollment forms will be mailed to physician members. To be assured of enrollment in the course, you may do so by sending your tuition fee of $62.50 payable to Honolulu County Medical Society, attention Irene Wong. Guaranteed enrollment assurance will be based on first 35 tuition checks received.

Dr. Irwin J. Schatz, chairman of the Department of Medicine of the John A. Burns School of Medicine, announces the start of Ground Rounds twice monthly for all community physicians and medical school faculty.

The first session will be held at 12:30 p.m. February 3 and thereafter sessions will be held at the same hour on the first and third Tuesdays of each month.

Each session will be devoted to a comprehensive examination of a particular topic in internal medicine by members of the Department and community physicians. Topic for the first session, to be moderated by Dr. Christian Gulbrandsen, will be "Modern Management of Systemic Lupus."



Prognosis For The Family Physician II

"Prognosis I" (HMJ Dec 1975) pointed out the difficulties facing the medical student who must "know it all" if he intends to go into Family Practice as a comprehensive care, primary physician. His prospect is more than merely challenging; it is awesome.

There is no argument with learning one body system well and becoming a specialist in it. However, people have a real need for a physician who has a broad knowledge of the whole person from both a physical and a mental point of view. As stated previously, this physician should not be just a triage officer, assigning his patients according to the part of the person that is afflicted. He should be a true counselor to his patient, his advocate in matters beyond the capacity of the patient to understand fully, and a coordinator of the team that is to approach a serious medical or surgical problem.

So, how is the medical student to plan his further years of training if he wants to get into this, the most difficult of all medical fields?

After a thorough grounding in the basics of medical knowledge while in medical school, including exposure to practice loci in several fields and especially a family practice preceptorship of quality, the new medical school graduate should enter a full training program in surgery, obstetrics and gynecology. Why?

Because, a family physician, particularly if he looks to a rural practice, MUST have a considerable training in the intricacies of performance in these fields. Aptitude and experience in these areas of medicine, wherein both diagnosis and treatment are so often "invasive", are a prerequisite for "comprehensive care". Even in urban situations, surgically and obstetrically experienced physicians in family practice are at a premium. A physician so trained need not be-

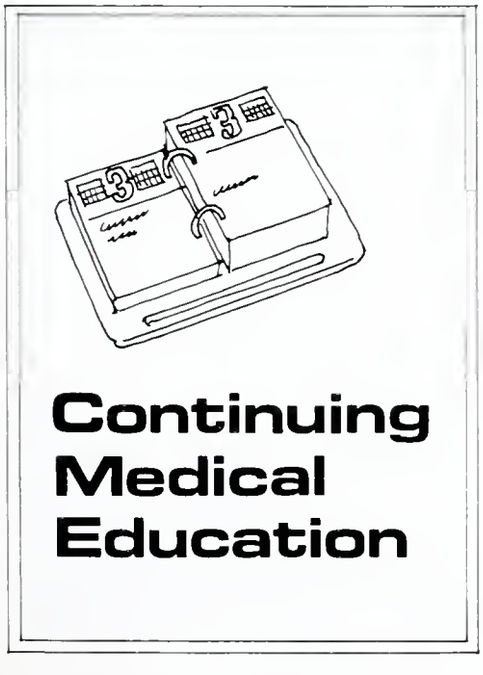
come a specialist, despite the incentive to "go all the way" and become a specialist in a limited field.

This is not to decry the aspects of internal medicine in general practice! Some physicians simply are either unsuited to using the knife, or have no particular love for surgery. Perhaps a residency in psychiatry instead will suit them better in preparation for family counseling (with heavy doses of internal medicine and pediatrics thrown in). But then, such non-surgical physicians will hardly, in the future, be permitted also to deliver babies—which means they will become, like the internists and pediatricians, semi-FP's. They may become "primary" but not "comprehensive" physicians.

In conclusion, then, our advice to the medical student headed for family practice is to go for general surgical training primarily; he should obtain obstetrical and gynecological training as well; he certainly should not ignore the medical, pediatric and psychiatric fields the meanwhile. If it takes five years for a full surgical specialist to mature, then surely a "specialist" in family practice should take more than three years of training!

There are many places in Hawaii, and a great many more on the mainland, not to speak of the world, where surgical and obstetrical skills and experience on the part of a family physician are not only desirable but almost essential for him or her to be able to provide comprehensive primary care. After that, the nearest medical centers and their satellites are becoming increasingly available as modern transportation and communication are being improved. These are the secondary and tertiary areas of medical care in which the primary physician can play an important roll as he accompanies his patient through the maze, guiding and monitoring and participating the while.

J.I.F.R.



CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS:

Ongoing

Kaiser Hospital
(Contact CME Dept. for further information)

Kauikeolani Children's Hospital
1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program

Kapiolani Maternity Hospital
1. Tuesdays—CME Program, 1:00-2:00
2. Grand Rounds, Wednesdays, 7:30-8:30
3. Visiting Professor Program (see Special Events)

Kuakini Hospital
1. Hematology Rounds, Monday, 1:00-2:00 p.m.
2. Gastroenterology, Tuesday, 8:00-9:00 a.m.
3. Oncology Conference, Thursday, 8:00-9:00 a.m.
4. Endocrine Conference, 2nd Wednesday each month, 1:00-2:00 p.m.
5. Medical Statistics, 3rd Tuesday each month, 1:00-2:00 p.m.
6. Renal Conference, Wednesdays, 1:00-2:00 p.m.
7. Kidney Biopsy Conference, Tuesdays, 1:00-2:00 p.m.
8. Visiting Professor Program (see Special Events)
9. G.I. Rounds, Tuesdays 8:00 a.m.
10. Infectious Disease Conference, Thursdays 1:00 p.m.

St. Francis Hospital
1. Medical Grand Rounds, Tuesdays (except 2nd), 1:00-2:00 p.m.
2. Surgical Grand Rounds, Fridays (except 4th), 7:30-8:30 a.m.
3. Tumor Conference, Mondays, 7:30-8:30 a.m.
4. Visiting Professor Program (see Special Events)
5. Clinical Pathology Topics, Mondays, 10:00-11:00 a.m.
6. Microslide Conferences, Tuesdays, 8:30-9:30 a.m.
7. Bone Marrow Pathology, Tuesdays, 2:00-3:00 p.m.
8. Basic Science Review & Research Conference, Thursdays, 1st & 3rd, 8:00-9:00 a.m.
9. Psychiatric Case Conference, Tuesdays & Fridays, 8:00-9:00 a.m.
10. Psychiatry for the Non-Psychiatrist, Tuesdays, 10:00-11:00 a.m.
11. Psychiatry Teaching Rounds, Thursdays, 9:00-10:00 a.m.
12. Medical Psychiatric Joint Teaching Rounds, Fridays, 11:00-12:00 noon
13. Surgical Mortality & Morbidity Conference, last Friday, 7:30-8:30 a.m.
14. Saturday Teaching Rounds, Saturdays (except 4th), 7:30-8:30 a.m.

Wahiawa General Hospital
(See Special Events)

Wilcox Hospital (Lihue)
1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:30 p. m. & 2nd Wednesday, 12:30 p.m. of each month in the Mabel Smyth Building. Contact HMA Office as dates are subject to change.

SPECIAL EVENTS
1976

January 5	"Emergency Psychiatry" (10-week course) at St. Francis Hospital (Mondays from 3:30-5:00 p.m.). Registration required. Contact Dr. Douglas Ostman at St. Francis Emergency Room.
January 17-24	Prenatal Medicine; USC at Royal Lahaina, Maui
January 18	Medical Emergencies in the Elderly, presented by the American Geriatrics Association and the HMA, to be held at Straub Clinic, 8:30-4:30. Speaker: Thomas Criley, M.D. Contact: L. Clagett Beck, M.D., 523-2311.
February 7-14	Surgical Diagnosis and Therapy; The Phil Thorek Postgrad Courses, 850 W. Irving Pk. Rd., Chicago, IL 60613 at Maui Surf Hotel, Maui; fee: $300.
February 9-11	"Workshop in Perinatal Infections" sponsored by ACOG & Kapiolani Hospital, at Kuilima Hotel (North Shore Oahu); 12 hours credit. For further information contact Wilma B. Schiner, R.N., Director of Training & Education, Kapiolani Hospital (955-6611).
February 15-19	Sports Medicine for Primary Physicians; Kuilima Hotel, Oahu; contact: Joy Lewis (for Dr. Richard Strauss)., University of Hawaii Conference Center, 2500 Dole Street, Honolulu 96822.
February 23-March 1	Practice Management for the Health Team; Medical Computer Services Association, 315-1107 NE 45th, Seattle, WA 98105; at Kauai Surf Hotel, Kauai; 20 hours credit.
March 8-11	Obstetric Anesthesia Conference—Part II., at Sheraton Maui Hotel, Maui, HI, sponsored by the L.A. Obstetrical and Gynecological Society. For further information, contact: California Medical Association, Committee on Continuing Medical Education, 731 Market Street, San Francisco, CA 94103.
March 9-10	Regional Meeting of the American College of Physicians, in Honolulu. Contact: Bernard W.D. Fong, M.D.

The seminars on "Sexual Counseling: Office Management of Sexual Problems" sponsored by the ACOG and University of Hawaii will be held on the following dates: (20 hrs. credit)

January 19-23	April 19-23	December 20-24
February 23-27	October 18-22	
March 22-26	November 22-26	

April 11-16 Colposcopy—A Refresher Course, at Lahaina, Maui; 25 hours credit.

For further information, write to: American College of Obstetricians & Gynecologists, Department of Continuing Education, I.E. Wacker Drive, Suite 2700, Chicago IL. 60601

Programs sponsored by the University of Southern California:

April 24-May 1	Chest and G.I. Radiology, at Royal Lahaina Hotel, Maui.
April 24-May 1	Pediatric Review, at Maui Surf, Maui.
April 26-May 1	Diagnostic and Therapeutic Skills, at Mauna Kea Beach Hotel, Kamuela, HI.
April 26-May 1	Emergency Medicine, at Kauai Surf, Kauai.

For further information, contact: Phil R. Manning, M.D., Associate Dean, Postgraduate Division, USC School of Medicine, 2025 Zonal Ave., Los Angeles, CA 90033.

Programs sponsored by Wahiawa General Hospital:

January 20	"Malpractice Problem" at Schofield Officers Club.
January 27	"Pediatric Fluid & Electrolyte Therapy" at Wahiawa General Hospital Dining Room.
February 24	"Mini-course on Pediatric Infection" at Wahiawa General Hospital Dining Room.

For further information, contact the Medical Records Department at Wahiawa General Hospital.

Visiting Professor Programs:

David R. Rovner, M.D., Professor of Medicine, Department of Endocrinology and Metabolism, Michigan State University, will be at St. Francis Hospital on January 22 and at Kuakini Hospital on January 19 & 26.

James C. Thompson, M.D., Professor and Chairman, Department of Surgery, University of Texas Medical Branch at Galveston, will be at St. Francis, Kuakini, Kaiser (Category 1) and at Queen's, Straub, and Tripler (Category 2) from January 12 through January 31.

For further information, contact the HMA Office of CME or the Medical Education Departments at the various hospitals.

OUT OF STATE
1976

January 24-25	"Ways of Healing: Ancient & Modern", University of California, at San Francisco; 12 hours credit. For further information, write: Continuing Education in Health Sciences, Ms. Mae Ling Yee, Room C135G, University of California, San Francisco, CA 94143.
February 16-18	"Pulmonary Function in Health & Disease," "Pediatric Pulmonary Disease" and "Newer Concepts of Care of Patients with Respiratory Disease" at Braniff Place Hotel in New Orleans. For more information contact: American Thoracic Society, 1740 Broadway, New York, N.Y. 10019, Attention: Mr. Ben Fontaine.
February 20-21	Koch Centennial Symposium at Hilton Hotel, Baltimore, Maryland: 16 hrs. credit. For more information contact: Mr. Sheldon Elman, Baltimore City Health Department, Division of Tuberculosis Control, 111 N. Calvert Street, C-232, Baltimore, Maryland 21202.
February 23-28	Diving Medicine at Truk, Micronesia; fee: $200. For more information contact: University of Hawaii Conference Center, (DMC-76), 2500 Dole Street, Honolulu, HI 96822.
March 25-27	Clinical Neuro-Otolaryngology, University of Pittsburgh School of Medicine; at Eye and Ear Hospital of Pittsburgh. For more information, write to: Sidney N. Busis, M.D., Course Director, Eye and Ear Hospital of Pittsburgh, Pittsburgh, PA 15213.

Courses of the NYU Post-Graduate Medical School:

January 8-February 12	"Pediatrics Perspective 1976—Infectious Diseases" at Booth Memorial Hospital, Flushing, N.Y.; 9 hours credit.

February 23-27	Seminar in Advanced Rheumatology; 30 hours credit.
March 22-26	"Advances in Clinical Surgery"; 25 hours credit.

For further information, contact: Office of the Associate Dean, New York University Post-Graduate Medical School, 550 First Avenue, New York, N.Y. 10016.

Courses of American College of Chest Physicians:

January 26-29	"The Young Lung" at Tamarron in Durango, Colorado, 16 hours credit.
February 2-6	"Practical Problems in Clinical Cardiology" at the Konover Hotel in Miami Beach, Florida, 24 hours credit.
April 21-23	"Clinical Diagnosis and Therapy of Lung Disease" at the Cleveland Clinic, Cleveland, Ohio; 19 hours credit.
May 13-15	"Wheezing—Obstructive Lung Disease in Adults and Children" at the Texas Children's Hospital in Houston, Texas, 18½ hours credit.

For further information, write to: Dale E. Braddy,M.S., Director of Education, American College of Chest Physicians, 911 Busse Highway, Park Ridge, Illinois 60068.

American College of Physicians: regional meetings and programs as scheduled below:

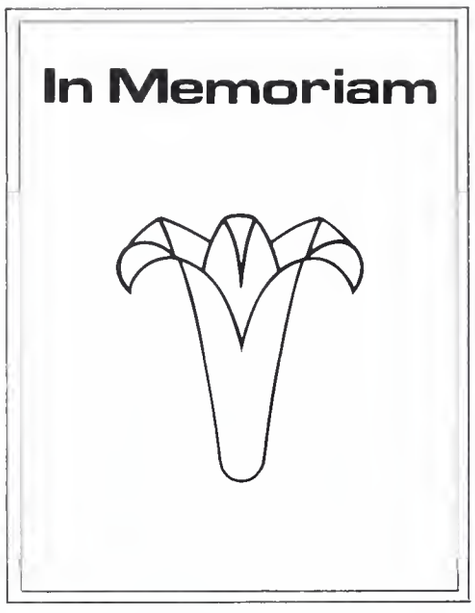
January 20-23	Internal Medicines and the Practice of Internal Medicine, 1976 at San Francisco, California
January 28-30	Infectious Diseases at Keystone, Colorado
January 28-30	Update in Infectious Diseases at King of Prussia, Pennsylvania
February 9-11	Basic Mechanisms of Disease at Shreveport, Louisiana
February 18-20	Clinical Immunology for Physicians at Gainsville, Florida
March 1-5	Specifically Treatable Diseases II at Philadelphia, PA
March 10	Rockefeller University, New York City (contact Dr. Felix E. DeMartini, 161 Fort Washington Ave., New York, N.Y. 10032)
March 15-18	"Neurology for the Internist" in Rochester, Minn.
March 18-20	"Clinical Recognition and Management of Heart Disease, 1976" in Tucson, Arizona.
March 24-27	"Hematology and Oncology, 1976" in Jackson, Miss.

For further information: American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

The 3-day seminars on Coronary Disease Exercise Testing will be held on: (13 hours credit)

January 23-25	Scottsdale, Arizona
January 30-February 1	Miami, Florida
February 13-15	Padre Island, Texas
February 20-22	New Orleans, Louisiana
March 5-7	San Francisco, CA
March 12-14	Orlando, Florida

For further information, write to: International Medical Corporation, One Inverness Drive East, Englewood, Colorado 80110.
Attention: Department of Professional Education.



William Nichols Bergin, MD 1907 - 1975

There must be others who knew Bill much better than I, and I hope that of those, one will write a more complete "In Memoriam".

Fresh out of World War II and glad to be back home in Hawaii, I landed with my small family on Lanai as assistant plantation physician to William Wilkinson, M.D., in March, 1946. Not long after, I was persuaded to join the T.A.P.P. — Territorial Association of Plantation Physicians — and went over to the big Island for the Association's annual meeting at the Volcano House. Dr. Bunnell, famous hand-repair surgeon from Stanford, was our special guest speaker. It was there that I met Bill Bergin and was immediately captivated by his warm personality, great sense of humor, fathomless well of jokes, and his insouciance, which hid an obviously concerned and dedicated "plantation physician" — the Hawaiian epitome of the family physician.

Bill was Honolulu-born, his mother a Nichols. He attended St. Louis College, as the high school was then named, and graduated in 1927. Creighton University and Medical School in Omaha gave him his M.D. in 6 years, in 1933. He was a Queen's intern, 1933 to 1935, and then went to practice in Holualoa in Kona. He remained a Big Island physician until his retirement from the Hilo Medical Group in 1972.

Bill was one of the early members of the A.A.G.P. Currently, only Varian Sloan (1947) Verne Adams (1948) and Bill Walsh (1948) of our membership outdate him. Bill joined in 1949, together with Wilmot Boone and ex-member Walter Ozawa. The Hawaii Chapter was not formally organized until 1951. Bill's membership of 26 years reflects nearly the full span of the Academy, which was founded in 1947. Bill received his degree of Fellow of the American Academy of Family Physicians in 1974.

A lasting impression of Bill as a fellow human being is based on his article in the HAWAII MEDICAL JOURNAL of Nov/Dec 1966. He bared his soul and his philosophy as a Catholic physician of high principle in his "Somebody's Going to Get Killed". As an exposition against abortion-on-demand, the treatise was well-reasoned, illustrating deep thought and considerable research into the history of man, and clearly stated. Like famed Albert Schweitzer, Bill Bergin expressed his lifelong and deep-seated reverence for life.

Bill's rich Irish humor was beautifully displayed in his memorable seriocomic self-illustrated article on sexing of Acrotheres Trestis, HAWAII MEDICAL JOURNAL Nov/Dec, 1972.

We in the Hawaii chapter shall miss Bill. We offer condolences to his bereaved family: his wife, Betty Barker Bergin; his veterinary physician son, William C., of Waimea, Hawaii; his daughters Kathleen (Mrs. Robert S.) Hill and Marjorie Kaaua, of Los Angeles, and Nancy (Mrs. John) Sherwood, of Hilo.

J. I. FREDERICK REPPUN, M. D.

Hawaii Academy of Family Physicians' Newsletter

J. I. Frederick Reppun, M.D.

NEW MEMBERS—We have only one to report this month: **Craig E. Kadooka** who is of the class of 1979 at the University of Hawaii School of Medicine. Welcome and may you stick with Family Practice all the way!

NEWS OF MEMBERS—**Mary Glover** has joined **Doris Jasinski** in the latter's office. It is of great interest to us all that Mary has also adopted a 9 y/o Vietnamese boy. **R.J. Harrison** of Lahaina, Maui is a new Active Fellow; he is already ABFP. **William R. Ahuna,** UHSM '75 and most recently in Seattle, has been dropped from our membership rolls.

CONDOLENCES—to **Lincoln Luke** on the death of his father on 11 December; Mr. William Luke was a banker and was once the treasurer of the city of Nanking, China.

H.M.S.A.—at the instigation of **Mary Glover** (and others in HMA) the matter of fairness in assignation of percentiles by Hawaii's largest carrier of medical insurance is being reviewed by the Hawaii Medical Association's Fee Survey Committee in conjunction with the Insurance Commissioner of the state. HMA's Johnny Won and HMA's president Cal Sia MD are following this closely; a report will be made to the Council soon, we hope.

QUEEN'S MEDICAL CENTER—Department of General Practice is headed by James Marnie MD whom we have long encouraged to join AAFP. **Doris Jasinski** reports that the department has only 8 active members, although 15 generalists use QMC as their primary hospital. There are 65 generalists on the Courtesy Staff, many of them retired physicians. A more active participation please!

ALASKA—Academy of Family Physicians is presenting the first annual "Ski & Sun" seminar in Ob, Neonatology and Family Counseling 21 Feb to 7 March. The Alaska contingent arrives in Hawaii on 27 February (Honolulu) and the Hawaii "Sun" portion will be held in Kona. Anyone interested, please call our Exec Sec.

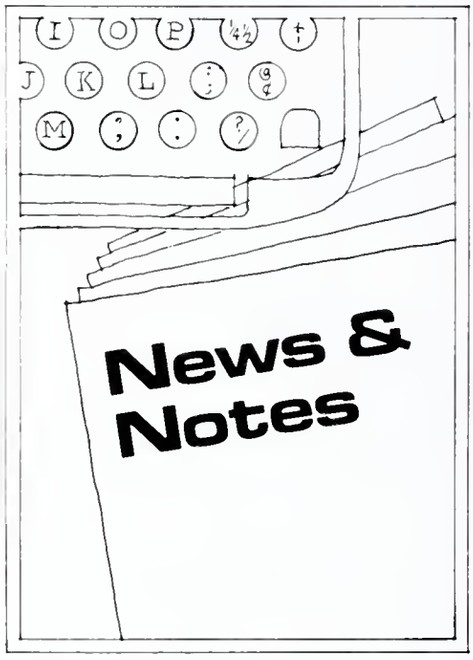
CALIFORNIA—an Altaville GP (80 miles East of San Francisco) closed his office and let all of his staff go when his malpractice insurance premium went from $2,000 to $22,000. He got a job instead, at the Mark Twain Medical Ctr. (personal reference).

The **BOIDO's**—are off to Thailand from mid December to the end of January for a jaunt; they have some adopted children there. They'll miss . . .

H.A.F.P. ANNUAL MEETING—at the Willows on 24 January. **Carl B. Hall M.D.,** President A.A.F.P., will install our newly to be elected officers.

KAHUKU—needs a Family Physician. Family Medicine of Hawaii, Inc. at the North Shore Clinic, is looking for a GP to replace Dr. Jeff McDevitt, who is leaving to practice in Kona, the Big Island; to start 1 March 1976. Phone Harriet Wikum 536-8309 or 293-9231

A HAPPY NEW YEAR to you all!



Henry N. Yokoyama, M.D.

Life in These Parts

We were saddened by the tragic death of Hilo surgeon **Jim Mitchel** caused by the earthquake and tsunami at Halape

HIGUCHI INSURANCE AGENCY, INC.

(808) 531-7091

HONOLULU COUNTY MEDICAL SOCIETY'S
INSURANCE PROGRAM ADMINISTRATOR

TERM LIFE INSURANCE
DISABILITY INCOME INSURANCE
MAJOR HOSPITAL INSURANCE
DEFENDANTS REIMBURSEMENT INSURANCE

Beach on November 29. **George Bracher** of Hilo described Jim as "an extremely gifted surgeon—a truly outstanding surgeon . . . This is a grave, and serious loss, not only of his surgical ability, but because he was an outstanding person as well . . . He was very involved in the community . . . The whole community is saddened and concerned . . ." Another Hilo colleague **Nicholas Steuermann** eulogized, "He was not only a very good surgeon, but was an excellent physician as well . . . He was extremely careful, conscientious and meticulous . . . It is a great loss to the community."

The Hawaii Chapter of the American Academy of Pediatrics surveyed 3 hospitals Straub, Children's and Kaiser's including 20 pediatricians and reported 188 skateboard injuries for July and August. There were 95 sprains, lacerations and bruises, 37 assorted breaks, one skull fracture, 18 brain concussions and 1 spleenectomy. chairman **Cal Sia** says, "It seems fair to state, with the figures we have, that the casualty toll is high. In no other individual recreational sport has one seen such a high injury rate as in skateboard riding."

The Hawaii Breast Cancer Detection-Demonstration Project reported 55 breast cancer cases in its study of 10,000 women aged 35 and over. **Fred Gilbert,** project director, said the number may well run as high as 60 or 70 when further tests are compiled.

Despite recommendations from the FDA, the US Public Health Service, and others to discontinue mobile X-ray units because of X-ray hazards, our Department of Health intends to keep its 3 mobile vans in active service. **Kirsten Vennesland,** chief of tuberculosis control, says that Hawaii leads the nation in the incidence of TB and that the vans are essential in helping to locate new cases. "More people die from a lack of X-rays than from it. TB is a lot more dangerous than the X-rays."

We gleaned the following from Tom Horton's column: "Kalaupapa's Charles Koch uttered the world's last line on an overworked subject. During a Honolulu visit, wife Katie had a morning date and no jewelry except her birthday present of perfectly matched pearls. 'Should I wear them so early in the day?' she worried. 'Sure,' Koch said, 'From a distance everyone will think they're puka shells!"

Every Sunday morning, near the Kapiolani Park Bandstand, 300 to 500 people gather for the "Marathon Clinic" established more than a year ago by **Jack Scaff, John Wagner** and **Alfred Morris.** The clinic is an LSD or "long-slow-distance" running program pioneered by Jack in 1973 as treatment for MI patients, but is now expanded to include anyone. Jack says, "Stress can't kill active people . . . What kills people is *unaccustomed* exercise . . . No marathon finisher has ever died from coronary disease . . . If you finish a marathon, whatever your age, your chances of suffering a heart attack are zero . . ." Jack agrees with the 550 physicians of the American Medical Joggers Association who assert that short term exercise—tennis, short jogs, baseball, etc. are of almost no use in preventing heart disease. He says, "Most sports go maybe 15 or 20 minutes and stop before your body switches from carbohydrate to fat metabolism. It's only when your body makes that switch that the exercise is doing you good."

Roberta Edel, clinical psychologist at Queen's, picked up a battered copy of "Alice in Wonderland" at the Out-of-Print Book Shop at Nat's General Store on Kekili. Roberta was reminded of one just like it that she had owned as a small girl in Nebraska almost 40 years ago. She looked inside and—incredible!—there was her name, "Roberta Roberts." Then she declined to rebuy it—"I don't know why. I guess a psychologist would have to explain why." (From Tom Horton's column)

GETTING THE DOCTOR ON THE RUN: Terri Cook, Advertiser writer, got the following comments from physician joggers . . . **Bill Harris** takes 10-mile bicycle rides, lifts weights, surfs and is a gymnast. Bill says, "I used to jog five miles a day, but then I got knee, ankle and Achilles tendon pain. I still recommend jogging and wish I could do more of it. **Winfred Chang,** who doesn't have time to exercise says, "I jog around my backyard at night. Sixty times around is one mile. If the hospital calls, I can hear the phone, get dressed, and be ready to go in no time." **Sharon Bintliff** plays soccer and will begin canoeing again in April. She also surfs and jogs 3 to 5 miles as often as she can. Sharon says, "Jogging is a real discipline. You discipline yourself to do other things, so why not discipline yourself to jog . . . I jog because I know exercise is good for me . . . I know from observing myself that my pulse is slower and I can eat almost anything I want and maintain my weight . . . I haven't lost weight, but I have lost inches . . . It's hard for women to improve around the thighs and waist simply by diet. They have to exercise." **Ed Dierdorff** ran in the 26-mile Honolulu marathon with distinction. Ed began running because he has a family history of heart disease and wants to keep his cholesterol down and improve his appearance. Ed gets an inner feeling of contentment when he jogs. "My body is in tune with the world and my mind is at peace. Of course that contentment doesn't always happen, but jogging is a good tranquilizer to soothe both physical and mental stress . . . Runners seem happier than most people."

Claude Caver's Repertoire

A lady recently widowed was complaining to a friend about the complexities and difficulties of collecting on her husband's life insurance policies . . . how she had to meet the insurance people, the tax people, the trust people, answer all the questions and fill intolerably endless forms . . . "I almost wish he hadn't died . . ." she said . . .

WWII joke . . . You know what the Eleventh Commandment was? "Thou shalt neither dip your wick in wax (WAC's) nor ride the breast of a WAVE."

WILLIAMS MORTUARY

"CHAPEL OF THE CHIMES"

1076 S. Beretania St., Phone 537-2587 **Ample Parking Adjoining Mortuary**

OVER A CENTURY OF SERVICE

"Service measured not by gold but by the Golden Rule"

MEMBER

National Selected Morticians, National Funeral Directors Association,
Order of the Golden Rule, Hawaii Funeral Directors Association

Progress report on the "Ban the Bra" movement . . . "It was holding up well for a while, but without visible means of support, it has begun to sag of late."

Professional Moves

Our oriental zodiac says the Year of the Dragon brings good fortune and happiness for the year. We are still in the Year of the Hare for news of our professional moves . . .

In November, former Medical Group surgeon **Bob Johnston** who had moved to Waimea, Hawaii in 1972 announced that he was retiring "due to the soaring costs of malpractice insurance." Bob, 66, had planned to practice a couple more years, but with the 175% increase in premium, he said, "It has just become economically unsound . . ." He plans to devote full time to raising horses . . . In November, **Mary Glover** joined **Doris Jasinski** at the University Medical Center Clinic, Ltd. at 1904 University Avenue; internist **Joseph C.S. Tsai** opened in Kaneohe at 46-132 Kahuhipa St.; OB man **George McGuire** and Eye man **George Plechaty** joined the Kaiser group. On Maui, GP **David Morrow** opened in Wailuku and on Hawaii, surgeon and OB man **Frank Ferren** and GP and industrial medicine specialist **Edwin Willett** formed the Kona Coast Medical Group in Kailua, Kona.

Going into December, we find pediatrician **Wayne McKinny** opening at the Aina Haina Professional Bldg., OB men **Philip McNamee** and **Carl Morton** opening a branch office at Niu Valley Shopping Center and internist **Margaret Rose** joining the Medical Specialty Clinic at 1481 So. King St. We also note that psychiatrist **Lothar Varady** opened a branch office at 677 Ala Moana Blvd. (Gold Bond Bldg.); neurologist **Kenneth Nakano** joined the Straub Clinic; Eye man **Tom Maeda Jr.** relocated to Suite 427 in the Professional Center Bldg.; and internist and former Kuakini Hospital medical director **Ray Huffman** joined the Windward Medical Center.

Health Department

That defatigable ball of energy, **Angie Connor,** is retiring in February as chief of the Health Department Children's Health Services Division. Angie came to the islands in 1948 and has since been chief of the Bureau of Maternal and Child Health and Crippled Children, professor at the UH School of Public Health, and Superintendent of Waimanu Training School before her present assignment. She has received the Puhlic Health Administrator Award and the Edgar Doll Award . . . for her past achievements . . .

Another ball of fire, our crusading Maui district health officer **Alice Broadhurst,** is also retiring to become medical director of Hale Makua, a Wailuku nursing home. Since becoming Maui health officer in 1970, Alice has fought with tooth and nail to reduce environmental pollution and upgrade public health services. She has operated free VD and hepatitis clinics, campaigned for extermination of typhus carrying mice in Kihei, and fought to upgrade water and sewerage systems on Maui, Molokai and Lanai. More recently she has pushed sanitation in food handling establishments and started a color-coded rating system for restaurants . . . She reflects modestly, "I didn't accomplish as much as I wanted, but I think I got things pretty well under way here."

Clinical psychologist **John Blaylock** is the new Chief of the Mental Health Division filling the position vacated by **Aldon Roats** who retired in July . . .

Tom Thorson's Corner

The southern preacher gave a fire and brimstone sermon one Sunday on the declining morals of the community. "Thar's just too much he'in' and she'in' going on . . . Then thar's that he'in' and he'in' and that she'in' and she'in' too . . . All this gotta stop before we all go to Hell!" A frightened youngster approached the preacher after church and in-



quired timidly, "Sir, you didn't say nothing about me'in' and me'in' . . ."

Sportsmen's Nite Hi Lites

Golfers:

Ably MC'd by **Bill Dang** . . . who promised, "Even those who lost will get a crying towel . . ." **Henry Tompson** in Guest Flight told the story of a great big gal getting married to an equally huge guy . . . After the wedding the groom was approached by a skeptic who asked, "You are both so big . . . How are you going to get together?" Replied the groom caustically, "You're the third guy with a short putter who's asked me that . . ." The guest flight prizes included a $50.00 prize donated by **Neal Wynn** and **George Mill's** perpetual trophy plus others . . . Winners were **Maruyama,** 1st; **Chuck Lockett,** 2nd; **Ray Hatake,** 3rd; and **Jerry Jaffet,** 4th . . .

In the MD flight, **Nobu Nakasone** shot a low gross 77. **Ernie Orinion** shot a 85-25-63 net for First Place. At net 65 was **Al Paraz** (80-15), followed by **Glenn Kokame** and **Tim Harrison,** with net 67. At net 69 were grouped **Ed Emura, Bill Dang, K.S. Tom,** and **Norman Nakamura.** At net 70 were **Al Chun Hoon** and **Joe Nishimoto.** Net 71 were shot by **Charlie Cachero** and **Dick Mitsunaga. James Tajima** was the only net 72. At net 73 were **Wini Lee, Don Maruyama,** and **Dick Omura**. At net 74 were **Doug Bell, Masa Koike, Ed Kagihara,** and **Mike Okihiro.** And at net 75 were **Shozo Ogawa, Paul Tamura, Phil Lee, Henry Fong, Ray Wong** and **David Sakuda.** At the other end of the scale were **Fred Lam Jr.** and **Early Kendall** with net 85's, **Allan Young** with net 86 and **Wyman Tong** with net 92. **Gayne Chun** shot hi gross 118 and received a crying towel and 2 free lessons from **Ernie Orinion** . . .

During the presentations, **Peter Kim** told a **Ralph Cloward** story about golfer **Al Ho** and his hearing aid which he turns off to concentrate on his golf. One day Al was raving about the new hearing aid he had just purchased . . . So Ralph asked, "What kind is it?" and Al looked down at his wrist watch . . .

Dick Ho complained how he had played 2 rounds with Al and that Al had not said one word to him . . . We also learned during the discussion from **Phil Lee** that when he takes Indocin for his golf bursitis, that it affects his libido . . .

Skin Divers:

Bill Moore reported on the Kalaupapa Skin Diving Tournament with only 6 participants . . . Bill was the tournament winner with a monstrous 6 lb. 23 inch long lobster which he described as a "double handed lobster" . . . The others were **Ted Tseu, Bill Davis, Henry Yokoyama,** and **Ed Quinlan.**

Fisherman:

Andy Morgan who was general chairman for the sporting events described the fishing derby as "pretty much of a fiasco." There were five boats lined up, but only 3 participants signed up. **Harold Sexton** caught the largest fish, a 29 lb. Mahimahi and **Ted Tseu** was second with a 27½ lb. Ono. Andy promised to hold the derby earlier next year in July or August when weather would be more favorable. He grumbled, "Many try it out and cop out."

Bow and Arrow:

Bill Davis reported that the torunament was cancelled this year for lack of entries . . .

Miscellany

It was joke swapping time during a lull in discussion at the Medicare Review Committee meeting at Mon Cher Ton Ton in December:



Effectiveness across the spectrum of most common forms of insomnia

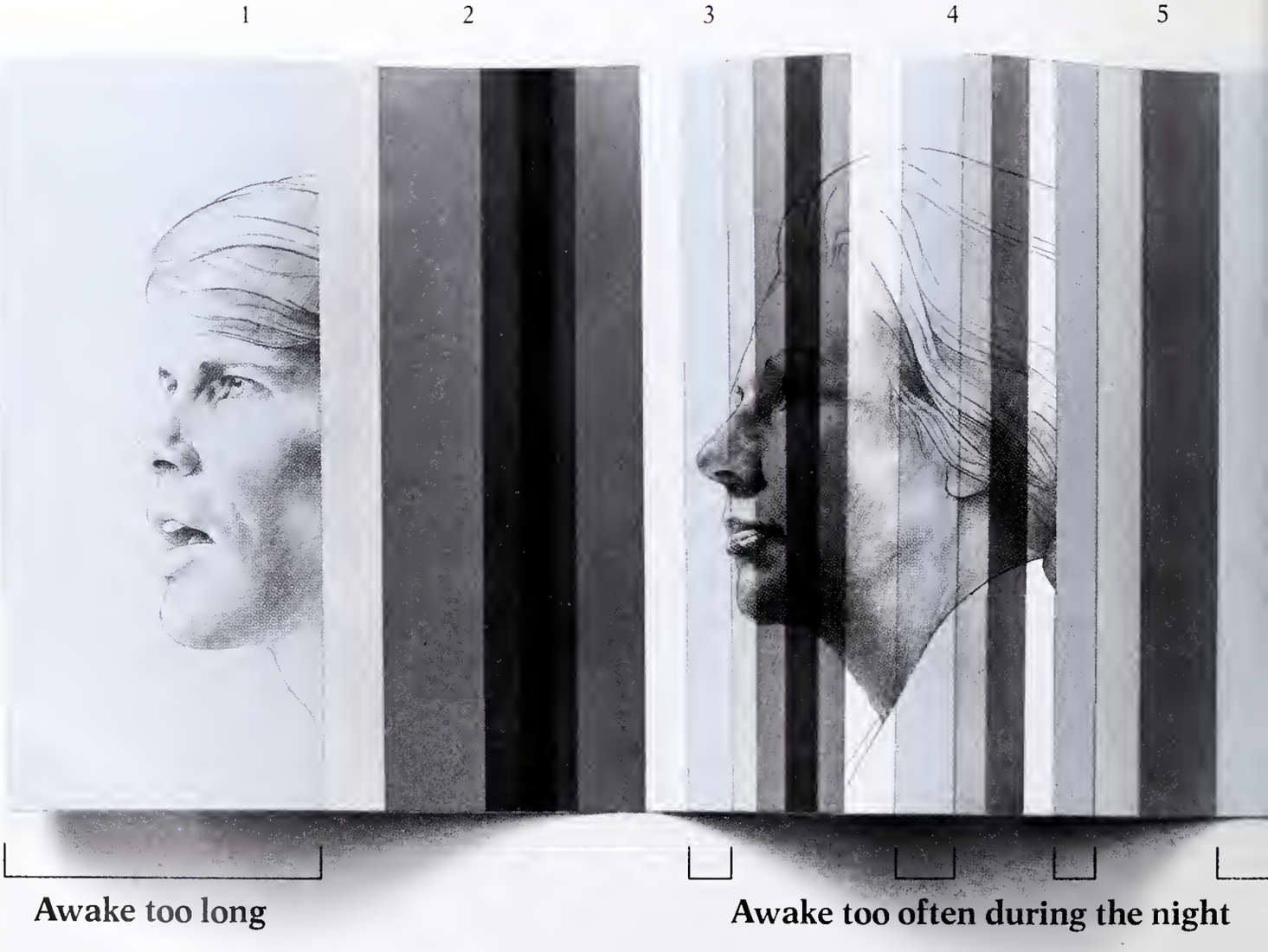
Awake too long, awake too often, awake too early...

These are the most common forms of insomnia, and may occur singly or in any combination. The night of troubled sleep depicted here comprises all three types. As the night progresses from left to right, each sleep stage is identifiable by its own shade of gray. Blue represents "Awake."

As you can see, this hypothetical "patient" takes well over an hour to fall asleep, awakens several times during the middle of the night and awakens too early in the morning.

Sleep Stages

- Awake
- REM
- Stage 1
- Stage 2
- Stage 3
- Stage 4



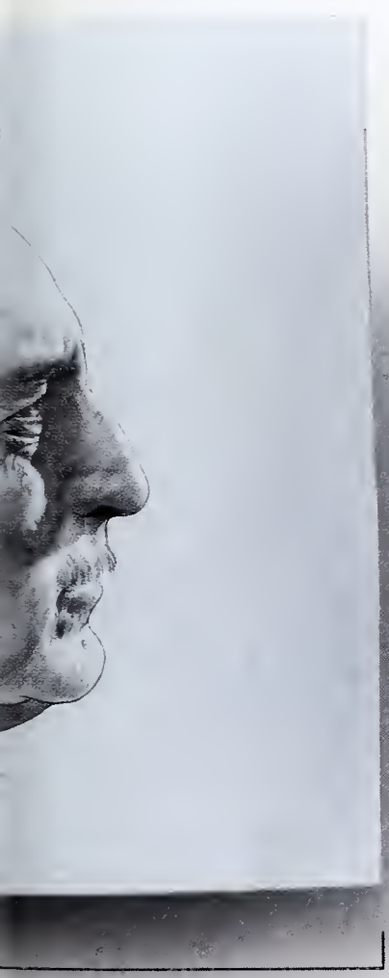
The insomnias most often occurring in young and older adults

For patients with trouble falling asleep (common in young adult insomnia patients), Dalmane (flurazepam HCl) 30 mg provides sleep within 17 minutes, on average. For those with trouble staying asleep or sleeping long enough (common in those over 50), Dalmane offers increased total sleep time with fewer nocturnal awakenings. These clinical results were demonstrated in studies conducted in four geographically separated sleep research laboratories.[1-4]

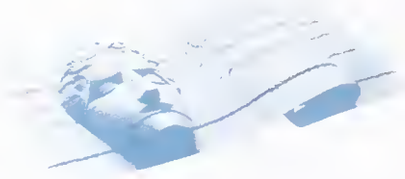
The relative safety of Dalmane (flurazepam HCl) is well documented

Dalmane (flurazepam HCl) is relatively safe and well tolerated; morning "hang-over" has been infrequent. The usual adult dosage is 30 mg; in elderly or debilitated patients, limit initial dosage to 15 mg to preclude over-sedation, dizziness or ataxia. Caution patients about possible combined effects with alcohol and other CNS depressants.

Broad-spectrum medication for the most common forms of insomnia



Awake too early



Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.*— usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.*— initial dosage for elderly or debilitated patients.

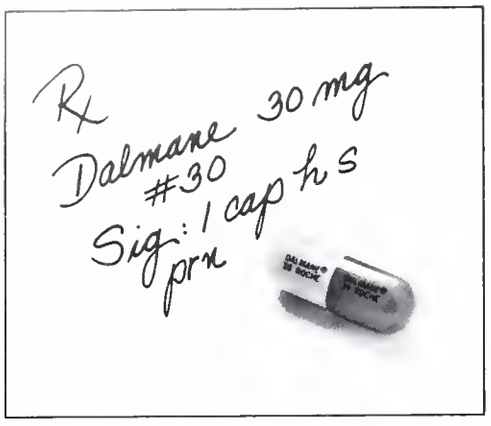
- □ induces sleep rapidly
- □ reduces nighttime awakenings
- □ lengthens total sleep time

ROCHE

Please see following page for a summary of complete product information.

Broad-spectrum medication for the most common forms of insomnia

Dalmane®
(flurazepam HCl) Ⓒ IV



Objectively proved in the sleep research laboratory, Dalmane

- induces sleep within 17 minutes, on average
- reduces nighttime awakenings
- provides 7 to 8 hours sleep, on average, without repeating dosage

Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

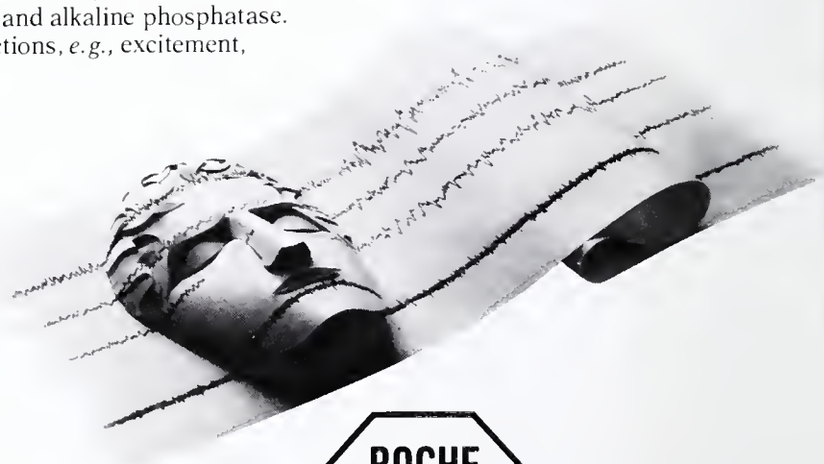
Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

REFERENCES:

1. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
2. Frost JD Jr: A system for automatically analyzing sleep. Scientific exhibit at the 24th Clinical Convention of the American Medical Association, Boston, Nov 29-Dec 2, 1970; and at the 42nd annual scientific meeting of the Aerospace Medical Association, Houston, Apr 26-29, 1971
3. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
4. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ



ROCHE

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Henry Fong told a **Walter Watt** special about Korea. It seems that VD was rampant so the area commandant gathered all the prostitutes and lined them up for the men to identify the carriers. There was one young attractive gal among all the old bags . . . Each man chose her rather than admit having slept with any of the others . . . **Doug Bell** told how a soldier could be thrown out of the Army if they got VD twice . . . So they were often given painful injections of Wild Root Hair Cream after the course of penicillin and they never would risk it again . . . **Lup Pang** then told about the Bishop asking the nun, "What would you have become if you had not become a nun?" The nun replied "A prostitute." The Bishop was astonished, "What did you say you would have become?" The nun again replied "A prostitute." The Bishop was apparently relieved. "For a moment I thought you had said Protestant . . ." Then it was Jerry's turn again. "There were these two fellows asking each other, 'Does your penis burn after intercourse?' The other replied, 'I don't know, I've never tried to light it.' "

At the annual Haiku Plantation Community meeting, the president announced that he will tell a Portuguese joke before getting on with the annual report . . . Someone in the audience protested, "Hey, I'm Portuguese . . ." "That's all right . . . I'll tell it real slow . . ." (Vic Hay Roe)

Physicians Speak Up

Former HMA president **Tom Frissell** has strong feelings about malpractice insurance and wrote: 'In the Advertiser article on physician liability insurance (11/18) Dr. Roth is quoted as implying such insurance is for patient protection. This is patently incorrect. The original intent was for the protection of the physician in case of a damaging judgment aganst him—it was viewed in the same context as his fire insurance or personal property insurance. This concept has been completely submerged and altered by a greedy society. The general public must accept a great part of the responsibility of the problem. After all, juries decide the amount of the rewards—and many of these awards bear no relation to reality. The fact that insurance is there (and insurance companies are disliked even more than physicians) influences jurors to award amounts that under other circumstances would never be considered. This statement has been confirmed to me by persons who have sat on such juries. At this juncture, I practice without liability insurance. There is a great question if the state will permit me to continue doing so. Certainly if I am forced to purchase it, my costs and subsequently the fees will rise. As a final note I might add that those who favor a state (government) solution to the problem will find they have a tiger by the tail and that medicine and the public both will be ill-served."

We were happy to see **Bill Moore's** and **Tom Thorson's** letters to the editor defending the $139,989 Medicaid fees paid **Robert Edwards** of Waianae. Bill wrote: Sir: On behalf of at least one dedicated physician in Hawaii, I resent the headline in the Oct 30 edition of the *Star Bulletin,* to-wit: "Doctors Enriched by Medicaid."

"To earn $139,939 in Medicaid fees, a physician in Hawaii has to see 50 to 55 patients every day, seven days a week, 365 days a year with no vacations, no nights off, no afternoons of golf, no postgraduate course; in fact no time for anything but his patients. Hawaii's citizens and probably those in many other states as well, are fortunate to have such devoted physicians to whom they obviously turn for medical care . . . You have done these physicians a disservice . . ." Tom wrote: "The headline and the lead paragraphs cast a strong implication that the physicians that accept welfare patients are engaged in a monumental ripoff on the public. Nothing could be further from the truth . . . The fact that one physician received a relatively large amount from DSS stands alone—the fact that he works in an area that has a very high incidence of DSS recipients and is available to that community seven days a week and serves them well is very much overlooked. His gross revenue from DSS must go to meet his costs of operation and I assure you that his "take home" income is in no way excessive."

Elected, Appointed, Honored

We congratulate **Harry L. Arnold,** our editor for his election as the 37th president of the American Academy of Dermatology. We can't think of anyone better qualified . . . Also to be congratulated are our new HMA officers viz president **William Dang,** president-elect **Calvin Sia,** secretary **Varian Sloan** and treasurer **Grover Batten,** and our HCMS officers, president **Doug Bell II,** president-elect **Ann Catts,** secretary **Pat Walsh** and treasurer **Walter Chang.**

At the recent San Francisco meeting of the American College of Surgeons **Shun-Kwung Liao, Ray Taniguchi** and **Harold Roger Netzer** were initiated as Fellows. **Mark Wentworth** of Ewa Beach was named as a fellow of the American Academy of Family Physicians at its annual convention in Chicago. **George Ewing** was elected vice president of the Western Region of the American Association for Clinical Immunology and Allergy at its annual meeting in Palm Springs.

On the Cancer front, **Jim Mitchel** (who was killed subsequently) was elected vice-president of the Hawaii Unit of the American Cancer Society; **Ed Dierdorff** was elected VP of the Windward Unit and **Bob Rose** chairman of Professional Information.

On other fronts: **Ike Kawasaki** was elected to the board of Kuakini Medical Center, **George Goto** is a director of Hawaii Planned Parenthood, and **Dick Lam** was given a Silver Anniversary Citation by Creighton University for 25 years of service to mankind and loyalty to the school. **John Watson** was named president-elect of the Western Conference of Prepaid Medical Service Plans. **John Corboy** was elected to the board of the Mental Health Association of Hawaii.

On the music front: **William Cody** is on the board of directors of the Honolulu Symphony Society and **Nobu Nakasone** is on the council of the Hawaii Opera Theatre. The **John Balfours** were hosts for the recent production."Nutcracker Suite" by the San Francisco Ballet and the Honolulu Symphony . . .

Miscellany

A plane crashed in the South Pacific leaving 12 survivors who were fortunate enough to swim to a nearby island.

There were 2 French businessmen and their secretary; 2 Italian businessmen and their secretary; 2 British businessmen and their secretary; and 2 HEW executives and their secretary.

As of our last report, the two Frenchmen had worked out a compromise of one having the secretary on Monday, Wednesday, and Friday, and the other on alternate days.

One Italian shot the other so he could have the secretary every day of the week.

The two British gentlemen shot their secretary so they could have each other.

The two HEW executives were still awaiting instructions from Washington.

(Tom Leinweber's contribution)

Hors De Combat

In October, **Djon Indra** of Hilo lost valuables including a camera and jewelry worth more than $920 when a thief broke in through the screen door over a weekend . . . But in Honolulu, **Herbert Hata** and his wife were held up at gunpoint by three gunmen wearing ski masks in their Manoa home on Nov 9. The robbers tied them up and fled with more than $25,000 in jewelry and $132 cash. Fire from a short circuit in

wiring caused $100,000 damage to **Isami Mirikitani's** Black Point home. Isami who still practices medicine from a wheel chair escaped unharmed . . .

The 17 physicians of the Maui Medical Group are urging their patients to contact their representatives in the State Legislature to work with the HMA to help set up an insurance program "which will protect both you and us." viz to establish proper malpractice insurance controls.

We were embarrassed to read in The Kokua Line the following:

"Q. What can be done about a doctor who continually charges for pills that clearly are stamped 'sample'? It has been brought to her attention, but the doctor does nothing to correct the matter."

Straub pathologist **L. John Lockett** in a letter to the editor took exception to **Jack Scaff's** statement "No marathon finisher has ever died from coronary disease. If you finish a marathon, whatever your age, your chances of suffering a heart attack are zero." "Vladimir Kuts, who had won Olympic gold medals in the 5,000 and 10,000 meter runs in 1956, died at age 48 in August 1975 of a 'heart attack' (*New York Times*, 8/19). There are reported cases of several marathon runners dying of necropsy-proven heart diseases either during or after a race. The relationship between exercise, sports and heart disease are complex; it is even debatable whether or not marathon running is indicated either in the treatment or prevention of coronary artery disease. Simplistic statements like Scaff's are becoming part of the pap of exercise physiologists and old wives' tales about atherosclerosis.

You could say that his statement is not just wrong, but dead wrong."

Jack Scaff replied: "Vladimir Kuts didn't run a marathon. As *The New York Times* reported, he did run 10,000 meters, which is 6.2 miles (one-fourth of the marathon distance), and ran that distance 19 years before his death at age 48. What running he did in the interim, if any, is unknown. It's never been claimed that anyone can run a marathon at age 18 and then be immortal. As I wrote to the *New England Journal of Medicine* on Dec 3: There has never been a case of documented death due to myocardial infarction in a nonsmoking individual within six years of such individual completing a marathon."

When the five member State Board of Acupuncture expanded the scope of acupuncture treatments to everything except six specified disorders viz cancer, open wounds, heart attacks, bone fracture, concussion, incurable disease and VD, the only medical doctor acupuncturist on the board **Julia Tsuei** who was absent took the board to task. "I fear more for the general public than for acupuncturists . . . The public will really be at a loss now if they think acupuncture can treat them for any kind of ailment. They will be very disappointed . . ." Thomas Kim, Board member, and a physical therapist cast the lone vote against the changes . . . board members voting for the changes were Setwin Teng, chairman and John Wheat Jr. and Lily Siou . . .

Sportsmen

Sports Briefs:

Mid Pac Thursday Club tournament winners: President's Trophy won by **Mike Okihiro . . .** September trophy won by **Ike Nadamoto** . . . October trophy won by **Mike Okihiro** . . . (Methinks the Ikes and the Mikes are winning them all)

Sharon Bintliff was a paddler member of the winning Healani Canoe Club in the recent all-women's race from Molokai to Ilikai. With her golf, tennis, surfing, jogging, etc. etc., we wonder if she is not a frustrated physical education instructor . . . rather than a director of a birth defects center . . .

Jack Scaff went off to run in the marathon in Albuquerque, N.M.

Bridge:

B.A. Weeks and partner placed 3rd in the Wailuku Bridge Club's master point game on Oct. 30.

HMA Tennis Tournament Results

Leabert Fernandez and **Yutaka Yoshida** (whose combined ages is 125) solidly trounced the second place winners **Ben Tom** and **Charley Ching** (whose combined ages are less than 80). We shall announce the other winners and participants as soon as we find out . . .

Oncology Dialogue

A 70 year old man with invasive adenoCA of the colon had suffered a respiratory arrest probably due to a decreased pulmonary reserve from an earlier pneumonectomy for Tbc . . . Moderator **Noboru Oishi** leading up to the discussion inquired about the immune status of the patient . . . **Gene Edynak** reported, "Fungal disease certainly lowers the immunological status . . . eg. fungal disease is associated with Hodgkins . . .The old time pathologists used to say, "Lymphomas followed tuberculosis like a shadow . . ." We don't treat so much active tuberculosis now so we do not know what the immunological status is in tuberculosis . . ." Pathologist **Grant Stemmerman** added, "The pattern of disease is associated with T cell formation. The incidence of colon CA is 1000 times normal in ulcerative colitis and 20 times in regional enteritis . . . In view of the clinical status of the patient, it is best that he be treated with a minimal of nothing . . ."

A 43 year old Kauai woman with hepatoma had ligation and intubation of the right hepatic artery for 5 FU infusion . . . Noboru offered, "Adriamycin is effective in 35% of these patients, though the drug is hepatotoxic . . ." Stemmy said, "Almost all female hepatomas are associated with Type B antigenemia . . ." Noboru: "Even if she is negative HAA?" Stemmy: "The antigenemia titre decreases with hepatoma . . . She should be treated maximally with chemotherapy because deaths are due to hepatic failure . . . The high SGOT may be secondary to tumor death rather than hepatitis or sepsis."

Our "Angels"

Page

Ayerst Laboratories
Premarin 6, 7

First Hawaiian Bank 31

Higuchi Insurance Agency, Inc. 22

Kaiser-AEtna
Crestside 24, 25

Eli Lilly and Company
Kefzol 10

McNeil Laboratories, Inc.
Tylenol 32

Pharmaceutical Manufacturers
Association 8, 9

Roche Laboratories
Dalmane 26, 27, 28
Valium 2, 3

Westwood Pharmaceuticals, Inc.
Presun 4

Williams Mortuary 23

YES CHECK*

*FOR PEOPLE WHO CAN'T QUITE PLAN AHEAD.



It's all yours: emergency money from First Hawaiian. **Yes-Check** is overdraft protection. We cover what you don't have. So if you need money and you're coming up short, you just write yourself a loan right out of your checkbook. It's that easy. **Yes-Check.** Money when there is no money. See a Customer Consultant at any First Hawaiian branch to apply.

FIRST HAWAIIAN THE BANK THAT SAYS YES®

A NON-ASPIRIN ALTERNATIVE TO COMPOUND ANALGESICS

Documented potency: Double-blind clinical studies[1,2,3] demonstrate the efficacy of TYLENOL® acetaminophen Extra-Strength capsules (500 mg.) in the control of moderate to severe pain.†

No aspirin side effects: Unlike most compound analgesics, TYLENOL Extra-Strength capsules contain no aspirin; they therefore minimize the risk of side effects often associated with aspirin, such as gastric irritation, hemostatic disturbances and allergic reactions.

So when your patients with minor conditions need greater analgesic strength than that provided by regular doses of the mild analgesic products, recommend or prescribe TYLENOL Extra-Strength capsules.

1. Hopkinson, J.H. III, et al.: Curr. Ther. Res. *16*:194 (Mar.) 1974.
2. Berry, F.N., et al.: Curr. Ther. Res. *17*:361 (Apr.) 1975.
3. Smith, M.T., et al.: Curr. Ther. Res. *17*:452 (May) 1975.

Precautions and Adverse Reactions: If a rare sensitivity reaction occurs, the drug should be stopped. TYLENOL® acetaminophen products have rarely been found to produce any side effects.

Available in bottles of 50.

†Episiotomy was used as a model to evaluate analgesia.

Recommend or prescribe 2 caps t.i.d. or q.i.d.*

*No more than a total of 8 capsules in any 24-hour period.

© McN 1976

McNEIL McNeil Laboratories, Inc., Fort Washington, Pa. 19034

TYLENOL® acetaminophen EXTRA-STRENGTH CAPSULES 500 mg.



FEBRUARY, 1976
VOL. 35, NO. 2

Hawaii Medical Journal

CONTENTS

Neighbor Island Mental Health 45
John C. Mebane, M.D., Asucena Kamahele, L.P.N., and James P. Carpentier, Ph.D.

The Emergency Medical Services Program of Hawaii 49
I. General Overview
J.K. Sims, M.D., Linda M. Wright, Judith A. Gavin, Thomas Y.K. Chang, M.D., Walter W.Y. Chang, M.D., Juliana Woo and Livingston M.F. Wong, M.D.

Continuing Medical Education 54

Editorials 53

Hawaii Academy of Family Physicians' Newsletter 55

HMA Council Meeting 58

HMA Newsletter 52

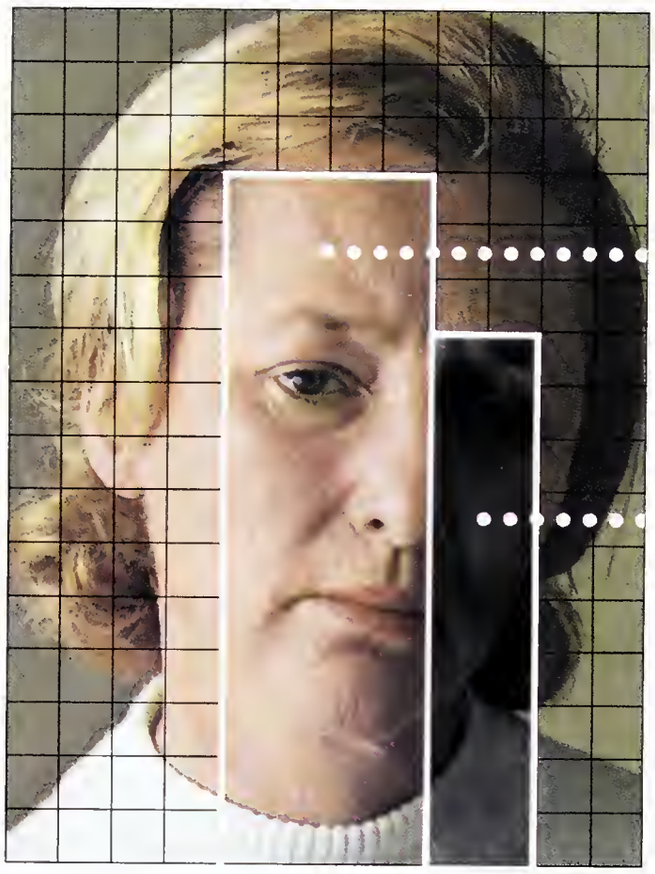
New Members 57

News and Notes 59

The Library
Acquisitions Division SP
University of California, San
Francisco
San Francisco California 94143

LIBRARY
U.C. SAN FRANCISCO
MAR 25 1976

Both often



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium®
(diazepam) Ⓡ IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

A NON-ASPIRIN ALTERNATIVE TO COMPOUND ANALGESICS

Documented potency: Double-blind clinical studies[1,2,3] demonstrate the efficacy of TYLENOL® acetaminophen Extra-Strength capsules (500 mg.) in the control of moderate to severe pain.†

No aspirin side effects: Unlike most compound analgesics, TYLENOL Extra-Strength capsules contain no aspirin; they therefore minimize the risk of side effects often associated with aspirin, such as gastric irritation, hemostatic disturbances and allergic reactions.

So when your patients with minor conditions need greater analgesic strength than that provided by regular doses of the mild analgesic products, recommend or prescribe TYLENOL Extra-Strength capsules.

1. Hopkinson, J.H. III, et al.: Curr. Ther. Res. *16*:194 (Mar.) 1974.
2. Berry, F.N., et al.: Curr. Ther. Res. *17*:361 (Apr.) 1975.
3. Smith, M.T., et al.: Curr. Ther. Res. *17*:452 (May) 1975.

Precautions and Adverse Reactions: If a rare sensitivity reaction occurs, the drug should be stopped. TYLENOL® acetaminophen products have rarely been found to produce any side effects.

Available in bottles of 50.

†Episiotomy was used as a model to evaluate analgesia.

Recommend or prescribe 2 caps t.i.d. or q.i.d.*

*No more than a total of 8 capsules in any 24-hour period.

© McN 1976

McNEIL McNeil Laboratories, Inc., Fort Washington, Pa. 19034

TYLENOL® acetaminophen EXTRA-STRENGTH CAPSULES 500 mg.



Hawaii Medical Journal

Published Monthly by the
HAWAII MEDICAL ASSOCIATION
(Incorporated in 1856 under the Monarchy)
510 S. Beretania St., Honolulu, Hawaii 96813

EDITORS

Editor, HARRY L. ARNOLD, JR., M.D.
News Editor, HENRY N. YOKOYAMA, M.D.
Assistant Editor, DORIS R. JASINSKI, M.D., M.P.H.
Contributing Editor, ROBERT H. MOSER, M.D.
Contributing Editor, J.I. FREDERICK REPPUN, M.D.
Book Review Editor, WINFRED Y. LEE, M.D.
Executive Editor, PAUL STEWARD

OFFICERS

President, WILLIAM W.L. DANG, M.D.
President-Elect, CALVIN C.J. SIA, M.D.
Past President, WINFRED Y. LEE, M.D.
Secretary, R. VARIAN SLOAN, M.D.
Treasurer, GROVER H. BATTEN, M.D.

County Presidents

Hawaii, KENNETH HUGHES, M.D.
Honolulu, DOUGLAS B. BELL, II, M.D.
Kauai RIEAZI REMITIO, M.D.
Maui, CLIFFORD MORAN, M.D.
Delegate to AMA, GEORGE H. MILLS, M.D.
Alternate Delegate to AMA,
HERBERT Y.H. CHINN, M.D.

Advertising Representatives
National:
HAWAII MEDICAL ASSOCIATION
510 S. BERETANIA STREET
Honolulu, Hawaii 96813
Phone (808)536-7702
Honolulu:
LILITH JURRY, Phone 946-0053

THE JOURNAL may not be held responsible for opinions expressed in papers, discussions, communications, or advertisements. The advertising policy of the HAWAII MEDICAL JOURNAL is governed by the rules of the Council on Drugs of the American Medical Association. The right is reserved to reject material submitted for editorial or advertising columns. All material for publication must be in the hands of the editor on or before the 10th day of the month preceding publication date. Reprints of original articles will be supplied at actual cost. A reasonable number of illustrations accompanying an article will be accepted for printing. The right is reserved to ask the author to bear cost of these when it is found necessary to do so.

Copyright, 1976 by the Hawaii Medical Association, Honolulu, Hawaii. 2nd class postage paid at Honolulu, Hawaii. Office of Publication: Mabel L. Smyth Memorial Building, 510 S. Beretania St., Honolulu, Hawaii 96813.



To the Editor:

Re: A lawyer's observation regarding doctors and medicine in the People's Republic of China

Dear Sir:

As a longtime member of the Medical-Legal Committee, I am submitting a lawyer's view regarding doctors and medicine in the People's Republic of China.

A group including Dr. Robert Ballard, sponsored by the US-China People's Friendship Association, spent the month of October 1975 in China. As all the group had a cold, dysentery or both, we were fortunate to have the doctor with us.

In Peking we visited a children's hospital set up in 1965. It dealt with children's surgery, Chinese medicine, acupuncture, physical therapy, infectious diseases and pediatrics. There are twenty wards with 600 beds, 2,000 to 3,000 outpatient children, 820 medical personnel, 340 nurses and 62 technicians. The majority of the staff members are women.

The hospital has the following tasks: Medical treatment by Chinese and Western medicine; teaching and training doctors and nurses; scientific research, and sending mobile teams to rural areas to help the peasants. Research is done to lessen common diseases and improve children's health.

We saw patient rooms and medical equipment and observed acupuncture treatments. A five-year-old girl had a needle placed in her navel to prevent bedwetting. The doctor said that by regular treatments she was improving. A fourteen-year-old boy with headaches for over three years had needles between the eyes and on the side of each eye, the lower left thumb and between the right thumb and finger. The boy said he could feel numbness. Another boy was almost healed of facial paralysis. The doctor said that when first seen his eye would not close and his lip was distorted. He had a needle in the lower lip, the ear and neck. A ten-year-old girl was being treated for myopia. A needle was in the side of her neck and between the thumb and finger on each hand. It is required that all doctors and nurses learn acupuncture. There must be a general idea of the disease to be treated by acupuncture which requires medical knowledge. For example, needles are sometimes placed in the base of the foot to treat a problem in some other part of the body.

There is a one-year course to train physical therapists. To specialize, the training is three years. All students are taught acupuncture.

continued page 56


w Xx Yy Zz
mail
$\frac{2}{3} \times \frac{3}{4} = \frac{6}{12}$
$\frac{4}{5} \div \frac{7}{8} = \frac{32}{35}$
$\frac{4}{7} + \frac{3}{7}$

The vulnerable ages

The first epileptic seizure is most likely to occur during early childhood and at the onset of puberty

About 9 out of 10 epileptics experience their first seizure before the age of 20—with the highest incidence between 5 and 7, when children start school, and at the onset of puberty, a time of physiological and psychic turmoil.[1] The most common type, grand mal, occurs in approximately 75% of epileptic children,[1] and more than 50% of patients who suffer initially from petit mal develop grand mal seizures before they reach the age of 16.[2]

Mysoline (primidone) for control of grand mal, psychomotor and focal epilepsy

At the onset and afterwards—used alone or as concomitant therapy, MYSOLINE may reduce the frequency and severity of major motor seizures—or even eliminate them. *Excellent* for control of grand mal. Valuable for control of psychomotor[1,3,4] and focal epilepsy as well.[5]

Add Mysoline when control with other anticonvulsants is inadequate—As concomitant therapy, MYSOLINE can improve seizure control in grand mal and psychomotor epilepsy. The combined use of phenobarbital, diphenylhydantoin, and MYSOLINE may have additive anticonvulsant effects without additive side effects.[6]

Change to Mysoline when other anticonvulsants fail—A changeover to MYSOLINE is frequently warranted when other anticonvulsants must be discontinued because of important side effects, or when grand mal seizures are refractory to phenobarbital, with or without diphenylhydantoin.[7]

Ayerst®

Mysoline® (primidone)

Tablets 250 mg.
50 mg.
Suspension 250 mg./5 cc.

May be the start of a better life for the epileptic

See following page of advertisement for prescribing information.

Mysoline® (primidone)

may be the start of a better life for the epileptic

initial and maintenance therapy for
grand mal, psychomotor and focal epilepsy

BRIEF SUMMARY
(For full prescribing information, see package circular.)

MYSOLINE® Brand of PRIMIDONE
Anticonvulsant

ACTIONS: MYSOLINE acts on the central nervous system to raise seizure threshold or alter seizure pattern. The mechanism(s) of action of anticonvulsant drugs is not known.

Primidone has anticonvulsant activity *per se*. In addition, its two metabolites possess anticonvulsant qualities. The major metabolite is phenylethylmalonamide (PEMA); the other is phenobarbital. In addition to its own anticonvulsant potential, PEMA potentiates phenobarbital.

INDICATIONS: MYSOLINE, either alone or used concomitantly with other anticonvulsants, is indicated in the control of grand mal, psychomotor, and focal epileptic seizures. It may control grand mal seizures refractory to other anticonvulsant therapy.

CONTRAINDICATIONS: Primidone is contraindicated in: 1) patients with porphyria and 2) patients who are hypersensitive to phenobarbital (see ACTIONS).

WARNINGS: The abrupt withdrawal of antiepileptic medication may precipitate status epilepticus.

The therapeutic efficacy of a dosage regimen takes several days before it can be assessed.

Use in pregnancy: Recent reports strongly suggest an association between the use of anticonvulsant drugs by women with epilepsy and an elevated incidence of birth defects in children born to these women. Reference has been made to primidone in several cases in which it was used *in combination* with other anticonvulsants; but its teratogenicity has not been conclusively demonstrated. The possibility exists that other factors, *e.g.*, genetic factors or the epileptic condition, may contribute to the higher incidence of birth defects. The data also indicate that the great majority of mothers receiving anticonvulsant medication deliver normal infants.

Anticonvulsant drugs should not be discontinued in patients in whom the drug is administered to prevent major seizures because of the strong possibility of precipitating status epilepticus with attendant hypoxia and risk to both mother and the unborn child.

When the nature, frequency, and severity of the seizures do not pose a clear threat to the patient, good medical practice requires that the physician weigh the expected therapeutic benefit of anticonvulsant therapy against possible risk on an individual basis.

Neonatal hemorrhage, with a coagulation defect resembling vitamin K deficiency, has been described in newborns whose mothers were taking primidone and other anticonvulsants. Pregnant women under anticonvulsant therapy should receive prophylactic vitamin K_1 therapy for one month prior to, and during, delivery.

The physician should weigh all of the foregoing considerations when treating and counseling epileptic women of childbearing potential.

PRECAUTIONS: The total daily dosage should not exceed 2 Gm. Since MYSOLINE therapy generally extends over prolonged periods, a complete blood count and a sequential multiple analysis-12 (SMA-12) test should be made every six months.

In nursing mothers: There is evidence that in mothers treated with primidone, the drug appears in the milk in substantial quantities. Since tests for the presence of primidone in biological fluids are too complex to be carried out in the average clinical laboratory, it is suggested that the presence of undue somnolence and drowsiness in nursing newborns of MYSOLINE-treated mothers be taken as an indication that nursing should be discontinued.

ADVERSE REACTIONS: The most frequently occurring early side effects are ataxia and vertigo. These tend to disappear with continued therapy, or with reduction of initial dosage. Occasionally, the following have been reported: nausea, anorexia, vomiting, fatigue, hyperirritability, emotional disturbances, sexual impotency, diplopia, nystagmus, drowsiness, and morbilliform skin eruptions. Occasionally, persistent or severe side effects may necessitate withdrawal of the drug. Megaloblastic anemia may occur as a rare idiosyncrasy to MYSOLINE and to other anticonvulsants. The anemia responds to folic acid, 15 mg. daily, without necessity of discontinuing medication.

DOSAGE AND ADMINISTRATION: The average adult dose is 0.75 to 1.5 Gm. per day. The initial dose is 250 mg. Increments of 250 mg. are added, usually at weekly intervals, to tolerance, or therapeutic effectiveness, up to daily doses not exceeding 2.0 Gm. A typical dosage schedule for the introduction of MYSOLINE (primidone) is as follows:

Adults and Children Over 8 Years of Age

1st Week 250 mg. daily at bedtime	*2nd Week* 250 mg. b.i.d.
3rd Week 250 mg. t.i.d.	*4th Week* 250 mg. q.i.d.

In children under 8 years of age, maintenance levels are established by a similar schedule, but at one-half the adult dosage. It is best to begin with 125 mg., with gradual weekly increases of 125 mg. a day, to a daily total usually between 500 mg. and 750 mg.

In patients already receiving other anticonvulsants: MYSOLINE should be gradually increased as dosage of the other drug(s) is maintained or gradually decreased. This regimen should be continued until satisfactory dosage level is achieved for combination, or the other medication is completely withdrawn. When therapy with this product alone is the objective, the transition should not be completed in less than two weeks.

MYSOLINE 50 mg. Tablet can be used to practical advantage when small fractional adjustments (upward or downward) may be required, as in the following circumstances:

- for initiation of combination therapy
- during "transfer" therapy
- for added protection in periods of stress or stressful situations that are likely to precipitate seizures (menstruation, allergic episodes, holidays, etc.)

HOW SUPPLIED: MYSOLINE *Tablets*—No. 430—Each tablet contains 250 mg. of primidone (scored), in bottles of 100 and 1,000. Also in unit dose package of 100. No. 431—Each tablet contains 50 mg. of primidone (scored), in bottles of 100 and 500. MYSOLINE *Suspension*—No. 3850—Each 5 cc. (teaspoonful) contains 250 mg. of primidone, in bottles of 8 fluid-ounces.

References: 1. Livingston, S.: Comprehensive Management of Epilepsy in Infancy, Childhood and Adolescence, Springfield, Ill., Charles C Thomas, 1972, pp. 6, 7, 584. 2. Grossman, H.J.: Ill. Med. J. *135*:260 (Mar.) 1969. 3. Scholl, M.L., in Conn, H.F.: Current Therapy 1973, Philadelphia, Saunders, 1973, pp. 675-7. 4. Metrick, S.: C.M.D. *37*:49 (Jan.) 1970. 5. Forster, F.M.: Med. Clin. North Am. *47*:1579 (Nov.) 1970. 6. White, P.T.: Wis. Med. J. *68*:178 (Apr.) 1969. 7. Millichap, J.G.: Drug Ther. *1*:15 (Oct.) 1971.



Ayerst®
AYERST LABORATORIES
New York, N.Y. 10017

"Kid, this stuff is the bananas."



Experts agree: when it comes to good-tasting banana flavor—without the unpleasant taste of paregoric—the makers of Donnagel®-PG really know their stuff!

For diarrhea

Donnagel-PG Ⓥ

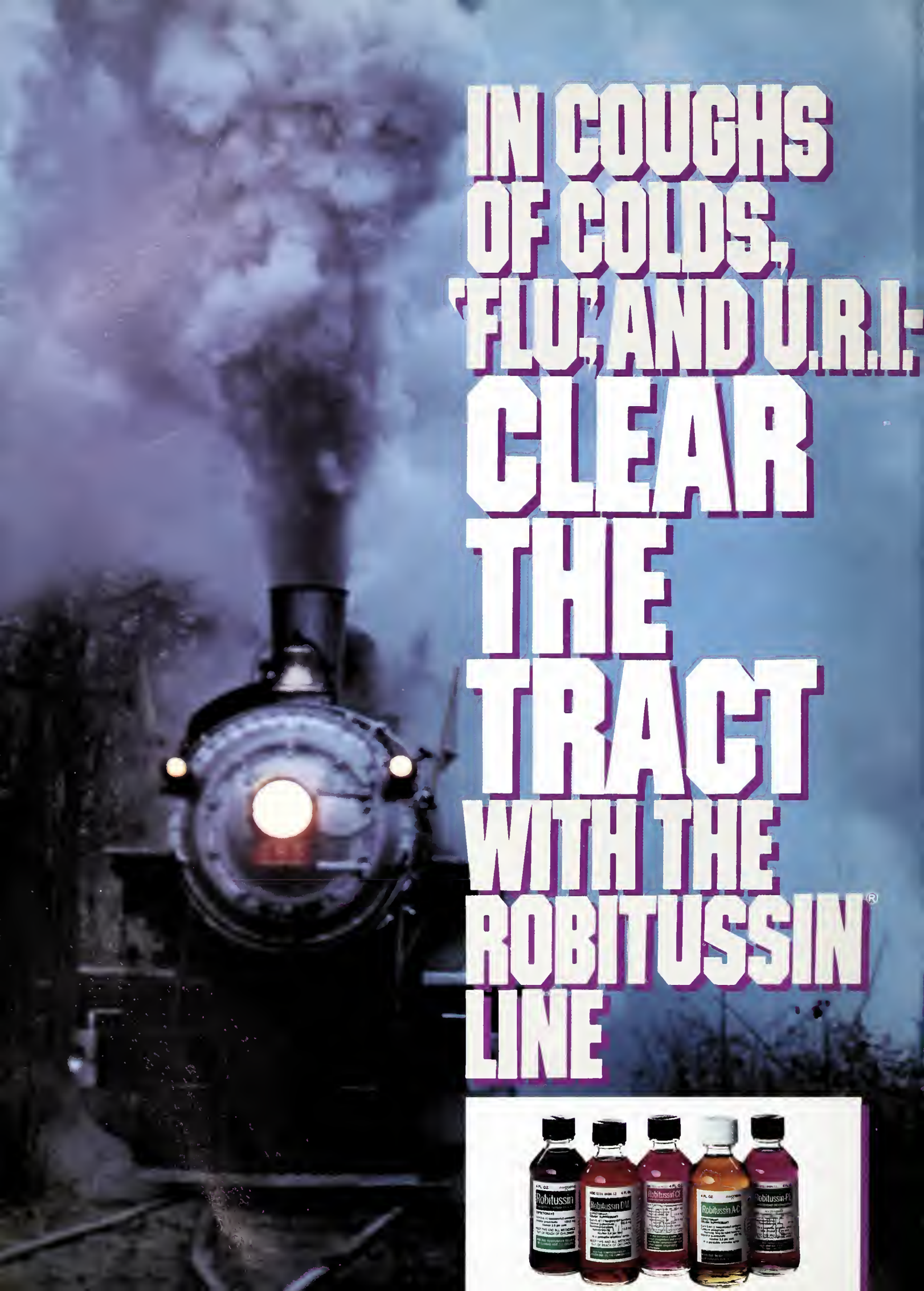
Donnagel with paregoric equivalent

Each 30 cc. contains:	
Kaolin	6.0 g.
Pectin	142.8 mg.
Hyoscyamine sulfate	0.1037 mg.
Atropine sulfate	0.0194 mg.
Hyoscine hydrobromide	0.0065 mg.
Powdered opium, USP (equivalent to paregoric 6 ml.) (warning: may be habit forming)	24.0 mg.
Sodium benzoate (preservative)	60.0 mg.
Alcohol, 5%	

Now with child-proof closure

A·H·ROBINS

A. H. Robins Company
Richmond, Virginia 23220


IN COUGHS OF COLDS, 'FLU, AND U.R.I.:
CLEAR THE TRACT
WITH THE ROBITUSSIN® LINE
Robitussin
Robitussin DM
Robitussin-CF
Robitussin A-C
Robitussin-PE

THE 5 RELIABLE ROBITUSSINS can really help clear the respiratory tract. All contain guaifenesin,* the expectorant that works systemically to help stimulate the output of lower respiratory tract fluid. This enhanced flow of less viscid secretions promotes ciliary action and makes thick, inspissated mucus less viscid and easier to raise.

*formerly named Glyceryl Guaiacolate

For productive and unproductive coughs

ROBITUSSIN®

Each 5 ml teaspoonful contains:
Guaifenesin, NF. 100 mg
Alcohol, 3.5%

For severe coughs

ROBITUSSIN A-C® Ⓥ

Each 5 ml teaspoonful contains:
Guaifenesin, NF. 100 mg
Codeine Phosphate, USP. 10.0 mg
(warning: may be habit forming)
Alcohol, 3.5%

Non narcotic for 6-8-hr. cough control

ROBITUSSIN-DM®

Each 5 ml teaspoonful contains:
Guaifenesin, NF. 100 mg
Dextromethorphan Hydrobromide, NF. 15 mg
Alcohol, 1.4%

Decongests nasal passages and sinus openings as it helps relieve coughs

ROBITUSSIN-PE®

Each 5 ml teaspoonful contains:
Guaifenesin, NF. 100 mg
Pseudoephedrine** Hydrochloride, NF. 30 mg
Alcohol, 1.4%
**Formerly contained Phenylephrine Hydrochloride 10 mg

Decongestant action helps control cough and clear stuffy nose and sinuses. Non narcotic.

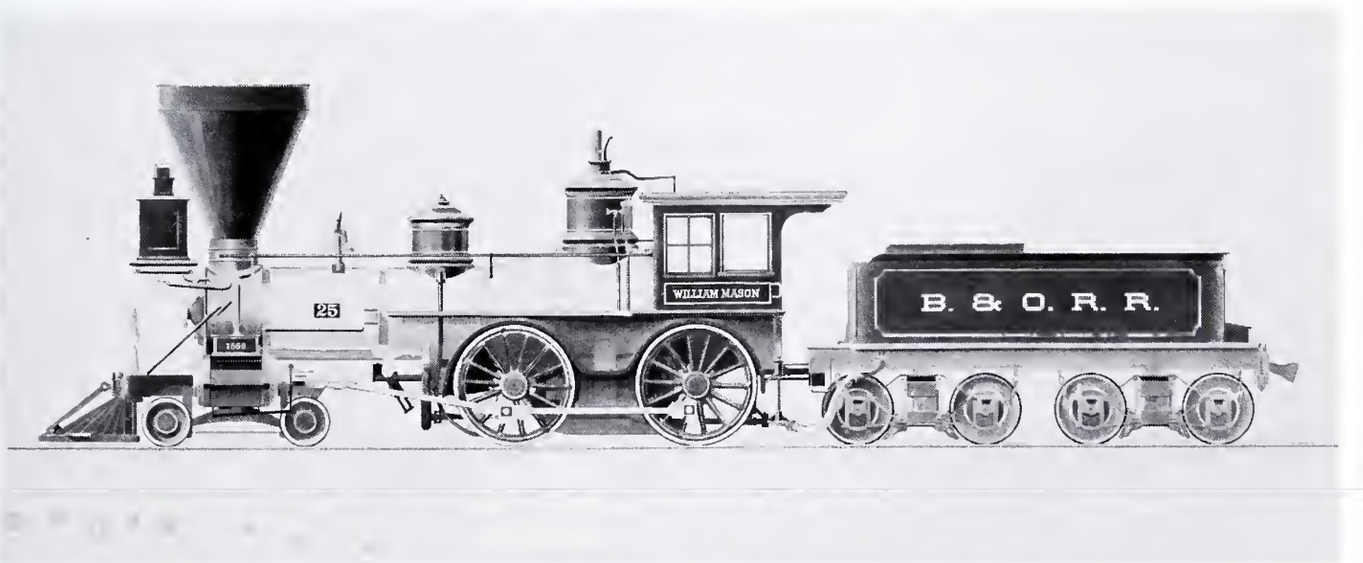
ROBITUSSIN-CF®

Each 5 ml teaspoonful contains:
Guaifenesin, NF. 50 mg
Phenylpropanolamine Hydrochloride, NF 12.5 mg
Dextromethorphan Hydrobromide, NF. 10 mg
Alcohol, 1.4%

All Robitussin formulations available on your Rx or Recommendation.

A. H. Robins Company, Richmond, Va. 23220 A·H·ROBINS

For many years Robins has spotlighted the expectorant action of the Robitussin cough formulations by featuring action photographs of steam engines. In keeping with this tradition, the company recently commissioned a well-known illustrator to render full-color drawings of several classic locomotives...accurate to the minutest detail. The first of the series is now available. To order your print suitable for framing, write "Robitussin Clear-Tract Engine #1" on your Rx pad and mail to "Vintage Locomotives," Dept. T4, A. H. Robins Company, 1407 Cummings Drive, Richmond, Va. 23220.



The William Mason (1856)

Kefzol®
cefazolin sodium

Ampoules, equivalent to 250 mg., 500 mg., 1 Gm., and 10 Gm. of cefazolin



Lilly

Additional information available to the profession on request.

Eli Lilly and Company
Indianapolis, Indiana 46206

600062

Neighbor Island Mental Health

JOHN C. MEBANE, M.D., ASUCENA KAMAHELE, L.P.N., *and* JAMES P. CARPENTIER, Ph.D., *Hilo*

The city of Hilo, on the windward shores of the "Big Island" of Hawaii, is unique among the communities of this island state. Peopled by one-half of the Big Island's total (75,000), it is farthest from the major center, Honolulu, on the capital island of Oahu. The relatively large size of the Big Island and its distance from the tourist center on Oahu have permitted a more gradual evolution of those features we associate with modern urban living. Hilo itself presents a community which is remarkably complete, self-contained, and able to sustain a special Polynesian-Oriental-American identity despite its proximity to the crossroads of the Pacific.

Mental health programs on the Island of Hawaii have developed gradually during the last twenty years as we achieved statehood. Primary objectives have been to service the scattered centers of island population, with main emphasis on community consultation and education and on early outpatient care to reduce the need for hospitalization. With time, hospital and day treatment services, 24-hour emergency care, and children's services have been added. The size and self-contained nature of the Hilo community lends itself remarkably to a very cohesive integration of the various community agencies, often within walking distance of each other, staffed frequently by friends, relatives, or next-door neighbors accustomed to an abundance of informal communication and grapevines which flourish with tropical luxuriance. For the mental health worker in training, the wealth of converging observational data about human problems permits a rich learning experience.

The present study is an effort to satisfy our own curiosity, as well as that of professional visitors, about the oft-asked questions: what kinds of problems do you see here? How is it different from "America?" Secondarily, since the private sector at present makes only a small contribution to our mental health services, we have a keen interest in our effectiveness, efficiency, and capacity to reach our community. A logical point of departure appeared to be a study of new admissions to the Hilo Counseling Center, the city's community mental health clinic. This would provide answers to some of our questions and would, hopefully, help us to deal more effectively with an increased demand for services which heavily taxes our professional staff.

Accepted for Publication August, 1975.

Attendance

During the 3-month period of September-November 1974, 170 clients were admitted to the Hilo Counseling Center. Of these, 122 (71.8%) were never previously known to us. The remaining 48 (28.2%) resumed contact as their clinical problems or life situations changed. An additional 31 made appointments which they failed to keep, an average of 11 per month, not alarmingly high, but vexing. Of all clients who visited the clinic, 48 failed to keep an appointment at one time or another: 36 missed one visit, 10 missed two, and 2 of our clients missed 3 or more visits during this 3-month period.

Age

The 18-over age group comprised 142 (83.5%) of our newly-admitted clients. Only 28 (16.5%) clients were 17 years of age or under. This latter figure is higher than estimates from mental health centers elsewhere in the State (7-10%). Nevertheless this is disturbingly low and a strong argument to pursue vigorously the establishment of children's mental health teams as the Division of Mental Health is now doing. We do not seek to enroll all troubled young people for direct clinic care, but this would be appropriate for a substantially larger number than we are now seeing. The obligation for more children's services in non-industrial Hawaii is even greater since our beautiful children can be looked upon as our most valuable export product.

FIG. 1—*Ethnic Analysis*

	GUDEMAN[1] %	HILO COUNSELING CENTER NO.			
Whites	32	66	39	Whites	49%
Portuguese		16	10		
Part Hawaiian	12	36	21	Part Haw'n.	21.5%
Hawaiian	3	1	0.5		
Japanese	30	26	15	Oriental	21.9%
Chinese	4	2	1		
Filipino	13	10	5.9		
Others (Indian, Negro, Puerto Ricans, etc.)	6	13	7.6	Other	7.6

Sex

Our staff were rather surprised to discover that 71 (41.8%) of our clients were men. We had expected a higher proportion of women but found only 99 (58.2%). A diagnostic breakdown according to sexes would help to clarify this. It may be that we are seeing more men now because this is a time of economic recession in an island community which is already close to the poverty level according to some criteria.

Ethnic Considerations

The ethnic mix in the Hawaiian Islands is well known throughout the world. Actually, it is far more complicated than most people realize. For example, a young man may present himself for assistance and identify himself to the clinic registration clerk as "Hawaiian." Later, when interviewed in detail, he informs the mental health worker that he is Hawaiian-Japanese-Filipino-Irish on his mother's side. Proudly, he may then add that his father was Portuguese-German-Spanish-Chinese! Nevertheless, we felt we should attempt an ethnic analysis, but hope such an effort may some day draw upon more reliable categories. It may well be that Captain James Cook had the last and best opportunity to do this in 1778. For purposes of comparison, we have also included data compiled by Gudeman[1] at the Hawaii State Hospital:

The current population of the Big Island is Japanese 38%, Hawaiian 22%, Caucasian 20%, Filipino 10%, and others (Chinese, Korean, Negro, Samoan, etc.) 10%. According to our study, therefore, there is an over-representation of whites among our clients and an under-representation especially of the Japanese and Filipinos. This is not surprising in that these latter groups, certainly among the older generations, seek support within their family or traditional religious groups, and may be more inclined to consult native healers. Unfortunately the true Hawaiian kahunas no longer exist, a tragic loss of native spiritual and healing insight. This is not to imply that among the younger generation we do not find superstitions, the placing and lifting of curses, etc. Our findings are in agreement with those reported by Tseng, McDermott, and Maretzki.[2] They have very effectively described a degree of alarm, confusion, and threat to personal privacy, which certain ethnic groups may perceive the mental health worker to represent. Because of the rich racial mixture of the islands, we attempt whenever possible to staff our facilities with professionals with whom our diverse population can relate comfortably. This becomes easier to accomplish as young people from the Islands complete graduate schools here or in the continental U.S. and hopefully, return home to begin their careers. Nevertheless, the key to positive relationships here in Polynesia seems to be the "Aloha spirit," not racial matching.

During the study period, the Hilo Counseling Center staff consisted of 11 professionals (two psychiatrists, two psychologists, four psychiatric social workers, one registered nurse, and two practical nurses). They were fairly evenly divided, six women and five men. The age range was from 28 to 57 with an average of 45 years. Several staff members, except for schooling, have lived in the Islands all their lives. The average length of residence was 28 years. The kaleidoscopic ethnic background of the staff parallels our clients: five are Oriental or Polynesian (one Hawaiian-Chinese, one Filipino-Spanish, two Okinawan Japanese, one Japanese); six are Caucasian with heavy representations of the Scottish, Irish and English, lesser mixes of German, Danish, Cajun, French, American Indian, and Lithuanian.

Area of Residence

The Hilo Counseling Center is the headquarters for the East, or Windward Hawaii Mental Health Service. Its catchment area runs roughly east of a line drawn from the northern to the southern extremes of the Big Island, across the summits of the two volcanic mountains, Mauna Kea and Mauna Loa. Although we served 116 (68.2%) Hilo residents during this study period,

we also saw 33 (19.4%) from southern areas such as Puna, Ka'u, and Volcano, and 21 (12.4%) from the northern areas along the Hamakua coast. These figures point up a need we already recognize to augment our contacts and availability to outlying rural areas. A transit system which is being established on the Big Island will aid in this but will not replace periodic field contacts by mental health workers.

Birthplace

The Hawaiian Islands became a favorite haven for the flower children, the hippies, the drug abusers, and other sub-cultures of the 1960's. Their presence is still felt rather strongly, although windward Hawaii with its heavy rainfalls is less hospitable. Nevertheless, since our data revealed that half our clients were whites, we wondered what the origins were of these and others.

We found that 85 (50%) were born in Hawaii County (the Big Island) and 22 (13%) in other Hawaiian Islands—just less than two-thirds of our caseload in this study. Mainland U.S. accounted for 49 (28.9%) clients, of whom we estimate some 10% were local residents for a substantial period of time. Other and unknown birth places accounted for the remaining 14 (8.1%).

Source of Referral

Most of our clients referred themselves (51, 30%), with family or friends (27, 15.9%) and private physicians or their office staffs (33, 19.4%) accounting for additional sizeable portions. Twenty-two (13%) of our clients came by referral from other health agencies such as the Awareness House Drug Abuse Program, the Salvation Army Interim Home for Girls, the Maternal-Infant Care Program, and Hilo Hospital. Since our clinic psychiatrists also staff the Hilo Hospital psychiatric service, we have an excellent opportunity to provide continuity of care when hospital patients progress to the clinic. Thirty-six (21.2%) of our clients were referred by schools, the Department of Social Services and Housing, and law enforcement agencies, including the police, the courts, and the probation department.

Diagnosis

See Figure 2. We have again included comparative figures from a study of inpatients at Hawaii State Hospital.[1]

Our clinic population contained a much smaller number of organic brain syndromes and functional psychoses, as well as a much higher neurotic population. Transient situational disturbances, marital problems, and non-specific conditions comprised a considerable fraction of our series (63%). This reflects the clinic's role as a front-line community treatment facility where acute problems may be seen at a time when a more definitive diagnosis is not yet possible. In addition, however, the staff consciously "diagnose down," preferring to avoid the labelling process wherever possible.

Our regular clinic population also contains a substantial and cumulative number of chronically ill psychotics. These are for the most part individuals who have been known to us through many years of relapses, remissions, and follow-up care, but their presence does not figure prominently in a study of a brief period of clinic admissions such as this.

Treatment

Our approach to our clients is a broad-based, eclectic team method. New clients in the clinic are more likely to be seen by a clinical psychologist or psychiatric social worker because the staff psychiatrists are heavily committed to hospital and medication follow-up duties. Interview psychotherapy is the main thrust of our intervention. Wherever possible, efforts are made to involve significant family members and to manipu-

FIG. 2—*Diagnosis*

	HILO COUNSELING CENTER		HAWAII STATE HOSP.
	NO.	%	(1)
Organic Brain Syndromes	2	1	23%
020.Psychoses not attributed to physical condition	10	6	42%
Neuroses	20	12	5%
Personality Disorders and non-psychotic mental disorders	21	12	14%
Transient Situational Disturbances	57	33.5	16%
Behavior Disorders of Childhood and adolescence	8	5	
Conditions without manifest psychiatric disorder and non-specific conditions	45	26	
No diagnosis made	6	3.5	
Unknown	1		

late the client's environment in favorable ways. One or more additional persons were seen in the treatment of 38% of this group of clients. This included spouses, children, other relatives, and at times, representatives of various community agencies.

During this three-month period, members of the Counseling Center staff also devoted 459 hours to community consultation and education efforts designed to deal with maladaptive problems as close to their source as possible.

Twenty-six (15.2%) of our clients were also seen by one of the staff psychiatrists, usually for prescription and evaluation of medication. In this era of psychotropic drugs, this figure reflects a fairly modest use of medication. To a lesser extent, the psychologist, psychiatric social worker, and psychiatric nurse also became involved in the treatment process at the request of the initial therapist.

In reviewing the follow-up status of this group of clients, we found that 127 (75%) were improved, 38 (22%) showed no change, and 5 (3%) were worse or the result was unknown. Most of our clients did well despite being seen for quite brief therapy: 48 (28.5%) were seen only once, 36 (21%) were seen twice, 23 (14%) had 3 visits. Fifty-four clients (31.7%) were seen from 4 to 9 times, and only 9 (5.3%)were seen 10 or more times. The fact that 25% were no better or were worse nevertheless presents a challenge.

It seems to be a rarity for the clinic to refer clients elsewhere to work out their problems. Only 4 individuals (2.5%) were referred on to other agencies or services, emphasizing our role as ultimate backup to all other agencies and practitioners dealing with troubled people. The clinic's own primary back-up is the Hilo Hospital psychiatric service where, in any given month, our staff psychiatrists provide direct services to an average of 22 admissions and consult with local physicians on 12 others. Wherever possible we attempt to reduce the need for hospitalization by using our day treatment program, whose staff also provide crisis-intervention services. There is still a considerable unmet need in Hilo for other alternatives such as half-way houses and transitional living facilities.

Figure 3 shows the diagnostic problems encountered in 65 patients who were admitted to the Hilo Hospital psychiatric service during the study period. Three of these were among the original 170 in the study group.

In those cases where our local hospital facilities are not sufficient, we arrange for transfer to psychiatric services on Oahu such as Hawaii State Hospital, Queen's Medical Center, and Tripler General Hospital. In 1974, 20 such transfers were arranged.

FIG. 3—*Psychiatric Admissions - Hilo Hospital September - November 1974.*

DIAGNOSIS (65 ADMISSIONS)	NUMBER
Schizophrenia	33
(Schizo-affective 10)	
(Paranoid state 2)	
(Other forms 21)	
Manic Depressive	1
Psychotic Depression	1
Organic Psychoses	4
Substance Abuse	10
(Drugs 3)	
(Alcohol 7)	
Neuroses	6
Personality Disorders	5
Life Adjustment Reactions	8
No Disorder or Deferred	2

Of the clients who consulted our clinic during this 3-month period, 114 (67%) were still active on January 31, 1975, and 55 (33%) cases had been closed. Of the 65 seen in September, 42 were open and 23 had been closed. Of the 49 seen in October, 37 were open and 12 had been closed. Of the 55 admitted in November, 35 were open and 20 had already been closed by the above cut-off date.

Conclusions

This survey is an effort to present an overview of mental health care in an area of the Hawaiian Islands which still retains a rural "old Hawaiian" identity. This 3-month study of clinic admissions reveals that we are reaching a fairly representative sample of our population with a treatment approach which is brief and frequently oriented toward situational crises.

REFERENCES

1. Gudeman HE: Ten-Year Profile of Hawaii State Hospital: A Statistical Analysis. Hawaii Medical Journal 26:3, 201-206, Jan.-Feb. 1967.
2. Tseng, Wen-Shing, McDermott, John F., Jr., and Maretzki, Thomas W.: People and Cultures in Hawaaii. An Introduction for Mental Health Workers. 1974, Dept. of Psychiatry, University of Hawaii School of Medicine.

The Emergency Medical Services Program of Hawaii—I. General Overview

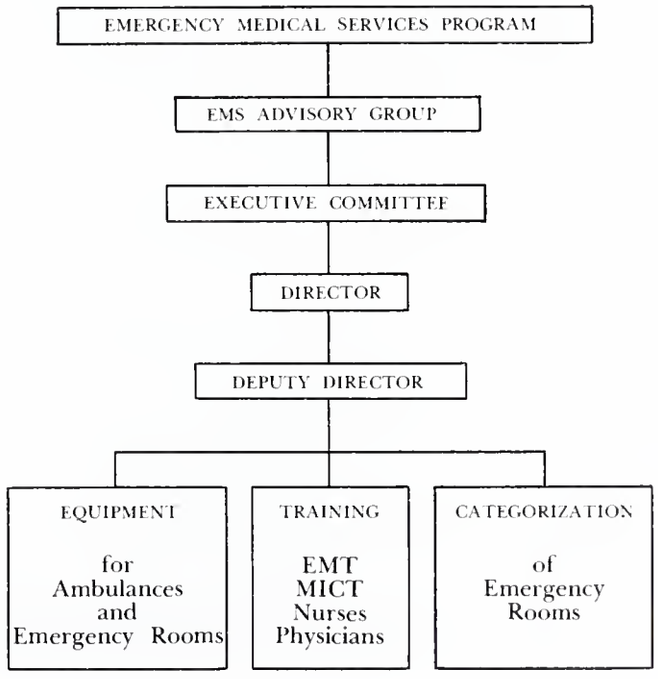
J.K. SIMS, M.D.,* LINDA M. WRIGHT,** JUDITH A. GAVIN,** THOMAS Y.K. CHANG, M.D.,† WALTER W.Y. CHANG, M.D.,†† JULIANA WOO*† *and* LIVINGSTON M.F. WONG, M.D., †*, *Honolulu*

● *In 1971 the Emergency Medical Services Program of Hawaii adopted a relatively new philosophy for emergency medical services programs that is best summarized as "improving the existing emergency medical services in Hawaii, in phases." This "improvement, in phases" concept has allowed the Hawaii Emergency Medical Services Program (EMS) to efficiently expand on the 1971 organizational objective[1] (Figure 1) into a comprehensive emergency medical services system by 1975[2] (Figures 2 and 3).*

The Hawaii EMS Program is thus far noteworthy for developing in Hawaii: (a) a uniform comprehensive computerized ambulance report form; (b) a well-functioning emergency verbal-telemetry radio communications system on Oahu (with neighbor island linkup scheduled for later this year); (c) well-equipped modern specification ambulances; (d) categorization of emergency facilities of all Hawaii's hospitals; (e) health education (in emergency medicine) capabilities, and (f) training programs for emergency care first responders—police/fire/lifeguard personnel, ambulance personnel (to two levels: Emergency Medical Technician or EMT, and Mobile Intensive Care Technicians or MICT or "ambulance paramedic"), emergency department nurses, and emergency department physicians . . . all to insure the continuity of emergency medical care delivery (Figure 4).

EMS in Hawaii has received considerable financial support from multiple sources (Figure 5) without which the system could not have developed. This financial support totals approximately $2.3 million thus far. Without the generous support from the agencies named, emergency medical services and care delivery capabilities would have progressed minimally beyond the 1970 level in Hawaii. Now Hawaii is a leading state in emergency medical care delivery in the U.S.A.

FIG. 1.—*Emergency Medical Services Program, Honolulu, Hawaii, 1971.*



The writing of this publication was supported by grant funds from the Department of Health, Education, and Welfare under Public Law 93-154.

*Training Coordinator, Emergency Medical Services Program (Hawaii), 1301 Punchbowl Street, Honolulu, Hawaii 96813; member, ACEP.

**Executive Assistant, Emergency Medical Services Program (Hawaii).

†Assistant City and County Physician, City and County of Honolulu.

††Former Assistant Director, Emergency Medical Services Program (Hawaii).

*†Health Educator, Emergency Medical Services Program (Hawaii).

†*Project Director, Emergency Medical Services Program (Hawaii); member, ATS.

Accepted for publication March 26, 1975.

FIG. 2.—*Emergency Medcal Services Program, Honolulu, Hawaii, 1974-1975.*

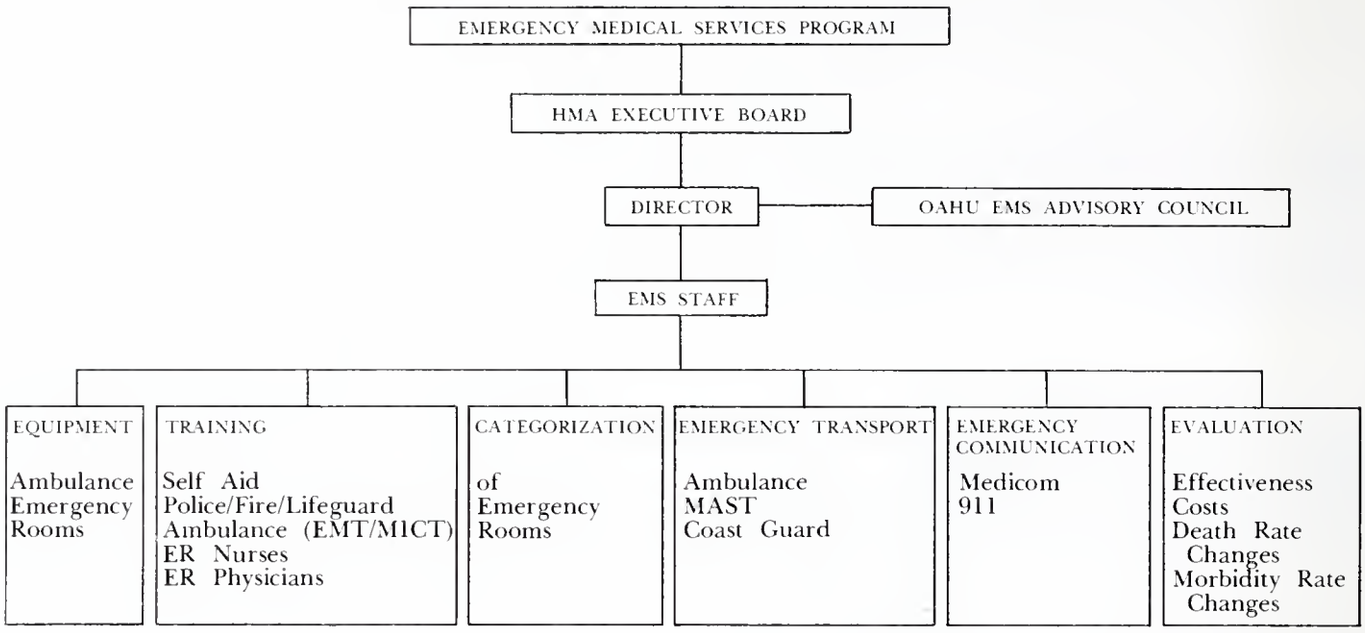


FIG. 3.—*Emergency Medical Services Program, Honolulu, Hawaii, 1974-1975.*

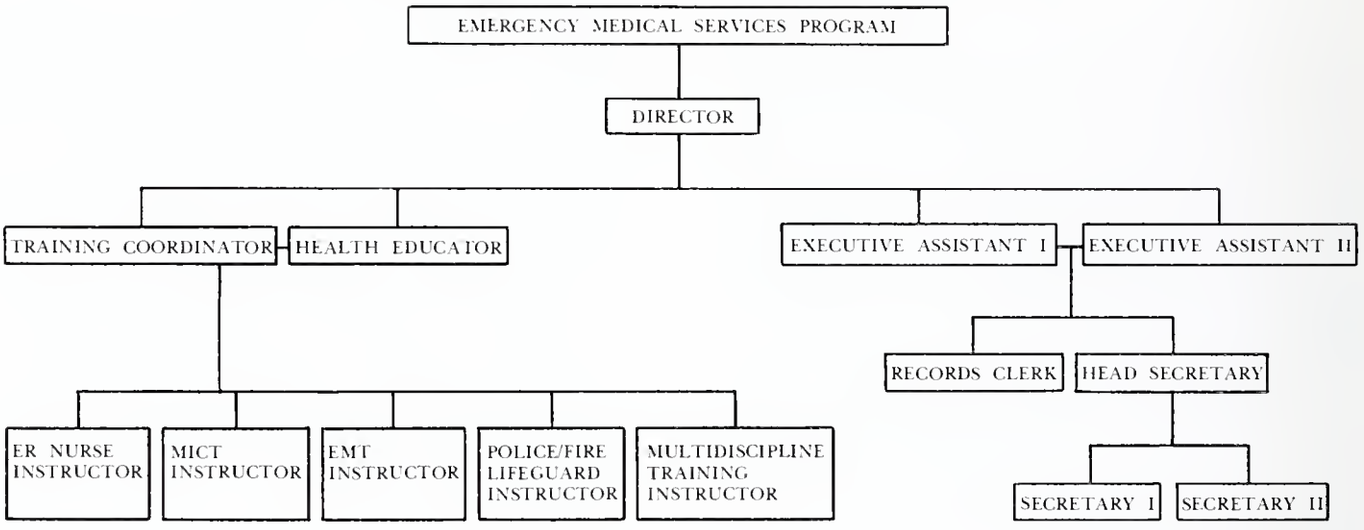


FIG 4—*Hawaii Emergency Medical Services Program.*

CONTINUITY OF PATIENT CARE
Victim (Self-aid)
First Responder (Lay)
Police, Fire, Lifeguard
Ambulance Personnel (EMT, MICT)
ER Nurse
ER Physician
ICU Nurse
Attending Physician

FIG. 5.–*Emergency Medical Services Program, Honolulu, Hawaii.*

SOURCES OF FUNDS

1. Department of Transportation (DOT) under National Highway Safety Act of 1967 (RM) (11/71 - 6/74)
2. Hawaii Chamber of Commerce Grant (1972)
3. Subcontract from Regional Medical Program (RMP) Service (11/72 - 11/74)
4. Grant from Department of Health, Education, and Welfare (DHEW) to City and County of Honolulu (7/74 - 7/75) subcontracted to Hawaii Medical Association (HMA) - Emergency Medical Services Program (EMS)

Oahu the Proving Ground

Through this funding, noteworthy accomplishments have been virtually completed on Oahu, and should be complete for the neighbor islands in 2-3 years. Oahu has been used as a proving ground for each of the Hawaii EMS projects, with the workable projects on Oahu being subsequently extended to the neighbor islands. This is the "improvement in existing emergency medical services in Hawaii, in phases" : . . Phase I—Oahu, Phase II—neighbor islands.

This "improvement, in phases" has not only allowed proven projects in EMS to be provided to the other islands, but has obviated the pitfalls of attempting to adopt a questionable program statewide simultaneously, that might result in the collapse of the entire project. The phase-development-implementation concept of Hawaii EMS has let Oahu be the site of aborting unworthy projects without sacrificing the time or monies of the neighbor islands. The primary disadvantage of such a phase-development-

implementation system is, of course, the necessary time-lag (generally in terms of months, and not years) of extending Oahu proven EMS projects to the neighbor islands.

The "phase-development-implementation" concept has been applied to virtually all of the projects listed above, excepting a few.

Uniform Reporting

The uniform comprehensive computerized ambulance report form is one of these exceptions; the ambulance patient record is the same for all the islands. This form documents comprehensively emergency medical care delivery by ambulance personnel. This form is being used on a trial basis from January 1, 1975, to December 31, 1975, during which the effectiveness of the form and emergency medical care delivery will be evaluated by computer. The computer printouts will provide not only statistics in emergency medicine, but will also be capable (through subprogramming) of pointing out areas where emergency medical care delivery can be improved. This information will be the subject of a subsequent report.

The Hawaii MEDICOM (medical communications) system is a UHF verbal and biomedical telemetry (eg, EKG transmission) radio communications unit, with capabilities for emergency hospital-to-hospital communications and ambulance (paramedic)-to-physician (hospital-based emergency department physician) communication. The MEDICOM unit allows continuous or intermittent physician supervision of emergency medical care delivery to the patient. Details of the system have been provided in preliminary reports.[3,4] A subsequent report will describe the MEDICOM network when all the Hawaiian Islands are interconnected operationally.

The ambulance services in Hawaii have been upgraded dramatically since 1971 according to national standards,[5] and the modern well-equipped ambulances are capable of providing continuous cardiac monitoring and advanced life support at the scene of emergencies and during emergency transport of the victim to hospital emergency facilities. Continuous communication with hospital-based emergency physicians is available to ambulance paramedics (the MICT's) via the MEDICOM COR (coronary observation radio) Units during cardiac emergencies. This system has proven to be effective on Oahu; extension to the neighbor islands is pending the completion of construction of neighbor island communication systems. The neighbor islands already have a number of modern specification ambulances that are well equipped, but minus the COR units.

Categorization of Hawaii's hospital emergency facilities has been an EMS project since 1971, and the initial categorization then was according to national standards.[6] Re-categorization is a designated part of 1974-1975 EMS activities. These categorizations are important in that they allow planning for funds for updating equipment, training, or personnel for these institutions through federal, state, county, or local sources.

"911" Part of EMS Program

Health education in emergency medical services will provide the populace of Hawaii with better self-help and emergency medical care access information. Consumer feedback is an integral part of this and involves everyone, since any person may be subject to an emergency situation. The publicity of "911" as a universal emergency telephone number for Oahu is an area of current emphasis in EMS (with the use of "911" being part of phase-development-implementation).

The training programs are designed to deal with the majority of levels of emergency medical care delivery (Figure 4) in Hawaii. Each of the indicated training programs will be discussed in subsequent reports.

Conclusion

The spectrum of training programs, categorization, report forms, etc. are a part of the EMS programs in several states.[7-156] These programs have been significantly reducing morbidity and mortality from emergency situations, particularly for heart attacks and trauma.[24,73,157-166] Hawaii now has a comprehensive modern Emergency Medical Services Program that has been funded with generous contributions and tax dollars, which have been used well. Hawaii's EMS Program has had much success in implementing multiple projects by designing the majority of its activities in phases. This phase-development-implementation philosophy has contributed to the development of an effective comprehensive emergency medical care delivery system for the people of Hawaii.

The Hawaii Medical Association-Emergency Medical Services Executive Board Members for 1974 and 1975 are as follows:

1974 Dr. Herbert Y.H. Chinn, Dr. Thomas P. Frissell, Dr. Wilbur S. Lummis, Mr. Masaichi Tasaka, Mrs. Sylvia Levy, Dr. Thomas Y.K. Chang, Dr. Alan Teitel, Dr. Russell I. Pierce, Mr. Tom Thorson, Dr. William W.L. Dang and Dr. Stanley Saiki.

1975 Dr. William W.L. Dang, Dr. Audrey Mertz, Dr. Stanley Saiki, Mr. Masaichi Tasaka, Dr. Ernest Lee, Dr. Russell I Pierce, Dr. Livingston M.F. Wong, Mr. Tom Thorson, Dr. Thomas Y.K. Chang, Mrs. Sylvia Levy and Mrs. Rosie Chang.

REFERENCES

References will appear in the author's reprints only.



H. Tom Thorson

Special Information—Recently a mailing was made from Vancouver, British Columbia by an organization called "CONDOR TRUST". The mailing included an application for malpractice insurance at reduced rates and solicited a $500 contribution to the capital of the trust.

Do not—repeat—DO NOT send money to the Condor Trust. The organization is not known to the British Columbia officials, the address is a mail drop, the phone number is an answering service, and all mail was being forwarded to Los Angeles. The named administrator is being prosecuted by the postal authorities. PLEASE BEWARE OF MAILORDER FAST BUCK SCHEMES!!!!!!!!!

President Dang returned from a leadership conference in Chicago after hearing Eugene Rubel present the government's position on the planning bill. (Your Executive Director recently protested the appointment of Rubel as the Administrator of the act.) Dr. Sammons, Executive Vice President pledged the AMA to fight when the government becomes "unreasonable" and promised to take the planning law (93-641) to court at the proper time.

Hawaii Medical Association will be represented by two delegates instead of one at the next AMA meeting. We had more than 1000 paid members on December 31, 1975—the actual number was 1001. The additional delegate will be Dr. Herbert Chinn, former alternate to elected delegate Dr. George Mills. Alternate delegates named by Dr. Dang, pending election at the annual meeting, will be Drs. Varian Sloan and William Dang.

Malpractice Legislation is moving apace. A number of bills have been submitted by various legislators on several aspects of the subject. The administration bill is in the final stages of drafting and should be in by the time you read this. In the meantime, we will be distributing regular bulletins concerning legislation that affects the profession. Your help will be needed in mustering support from your patients by asking them to write to their legislators.

Indiana Reports that their innovative legislation in malpractice has not been a panacea. Dr. Steven Stowe, Governor of Indiana and a former Family Practitioner, urges all states to find their own solutions with the hope that from the fifty state approaches, a composite solution may be found.

Alaska doctors found themselves in a paradoxical situation—when they could not buy insurance at any price, many of the surgeons decided to leave the state and then found themselves threatened with suits because they conspired to abandon patients—You can't win!

FTC Action concerning physician advertising will be fought by the AMA. FTC claims that AMA violates anti-trust laws by prohibiting physician members from soliciting patients.

Today's Health magazine has been sold by AMA to Hospital Media, Inc., Nashville, Tenn. Little change is expected in the format or the distribution of the magazine.

IRS Regulations relative to advertising income of professional journals have now been published. There has been a running discussion about this for over twenty years with the IRS leaving the decisions largely to auditors with no guidelines to follow. The regs are now being studied.

AMA Recognition Award applications can now be filed at any time rather than on a three year cycle. Beginning this year AMA members will pay no fee for the application. Non-members will pay $25.00.

Pacemaker Trouble—Message from Medtronic Pacemakers is to the effect that XYTRON brand implanted pacemakers models 5950, 5951, 5912 and 5913 may be defective. Patients should be monitored every two weeks.

Laetrile trouble pops up. Some patients have abandoned regular chemotherapy and/or radiation therapy for treatment by laetrile. The preparation is forbidden in interstate commerce and

disapproved for cancer therapy by FDA. Five were recently convicted and sentenced in San Diego for its use. Information relative to patients using this course of treatment should be forwarded to HMA.

Time to Turn Out and Turn On with HAMPAC. This is a political year and one of the most crucial that medicine ever faced. Every doctor owes it to himself and the profession to become involved in some way. Support a candidate, work for legislation, join HAMPAC and give of yourself. If you have not already included your 1976 HAMPAC membership with your annual dues, then make out your $20 membership check now payable to HAMPAC and mail direct to HMA headquarters, 510 S. Beretania St., Honolulu, HI 96813.

Openings—North Shore Clinic at Kahuku needs a Family Practitioner. Call Harriet Wikum at 536-8309 on Monday, Wednesday and Thursday or at 293-9231 on Tuesday or Friday.

Emergency Medical Care at St. Francis Hospital needs a physician. Contact D. C. Ostman, M.D. at St. Francis Hospital Emergency Dept.

Court decision—Arnie Siemsen reports that Judge Pence ruled that patient safety overshadowed economic considerations and ordered that nurses staff the dialysis unit during the nurses strike.

International Health Care Symposium in Scandinavia (Copenhagen and Stockholm) including seminars in wound management, cardiovascular workup, and clinical dentistry. Seven data options. Interested physicians contact Mr. Douglas T. Cole, Regional Manager, Trans International Airlines, phone 841-3651.

PATIENTS WITH ALCOHOL PROBLEMS?

call

HAWAII COMMITTEE ON ALCOHOLISM

Consultation,

Counselling,

Referral

524-1144

International Health Evaluation Association, Kyoto Conference 1976—"The Sixth Annual Meeting," November 10 through 13, 1976, Kyoto, Japan—Kyoto Grand Hotel. Contact Fred Gilbert, M.D. at 523-2311 if interested.

At the HMA-EMS Executive Board meeting of January 27 it was recommended that the Hawaii Medical Association membership be asked to donate their 1975 PDRs to the HMA for the EMS-MICT units.

Dues Are Due!!!

Early Payments on Dang Plan exceed expectations. First payments are due by March 31, 1976.



Relative Values and a Perspective

It is probably safe to say that most physicians, or at least the ones who hospitalize patients, are sympathetic to the cause espoused by the nurses.

The nurses feel they deserve, they are entitled to, and they want a better remuneration for their responsibilities and their work. If anything, this strike on the part of the nurses in six Oahu hospitals and on Kauai, will prove to attending physicians, to the house staffs, and particularly to the patients hospitalized during the strike, that the nurses with their contribution to medical services had been taken too lightly, too much for granted, and, therefore, somewhat belittled by all of us.

It is also true that the hospital administrators themselves will undoubtedly admit that, for too long, the entire gamut of hospital personnel had been at the low end of the wage scale. The relatively recent upward trend of adjustment of these wages is probably the prime factor in hav-

ing caused health care costs to rise. The government, which one would expect to be the most aware of this factor, is the one howling the loudest in the media, causing harm to all "health providers", a term that lumps doctors and nurses and hospitals and allied health professionals together.

It is, therefore, quite apparent to physicians, in considering the dispute between the nurses and the hospitals, that "the other side" has a case to make too. We realize all too well that it is our patients who have to be hospitalized who must ultimately pay the higher bill—or the higher medical insurance premium. Hospitals can easily pass on the higher costs of wages; the insurance carriers can just as easily do the same. The patient can only say: "The buck stops here, and I have to pay it."

What is very difficult for us to understand about this dispute is the large discrepancy in the mathematical figures placed on the bargaining table. It borders on being ridiculous!

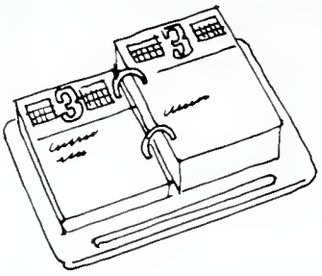
Presumably the dispute will be settled someday (or, hopefully, will have been settled by the time this is published) and the public will have to pay the bill. However, guaranteed NOT to be settled probably for a long time, will be a scale of relative worth of one job as against another, which would make it possible for society to give everyone a raise in proportion, or request a reduction, again in proportion, if such is badly needed for the economy.

The Hawaii Medical Association, ever since the days of Steele Stewart M.D., has addressed itself to the problem of relative values of the thousands of procedures and services rendered by a wide variety of practitioners. Its best effort so far has been the bound book: Hawaii 1970 RVS. HMA is working continually to keep the RVS current and complete.

Why cannot the same type of energy be directed toward establishing relative values of work effort within the entire medical/health field? And, if we can set an example there, after reaching a consensus that is acceptable, then perhaps the idea can be expanded to include the entire span of human endeavor: From garbologist to cardiologist, from coal miner to proctologist, from plumber to urologist, and from airline pilot to CCU nurse!

J.I.F.R.





Continuing Medical Education

CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS:

Ongoing

American Cancer Society, Hawaii Division
1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m.

Kaiser Hospital
(Contact CME Dept. for further information)

Kauikeolani Children's Hospital
1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program

Kapiolani Maternity Hospital
1. Grand Rounds, Wednesdays, 7:30-8:30 a.m.
2. Resident Conference, Tuesdays (except 1st), 1:00 p.m.
3. Ob-Gyn Department Meeting, 1st Tuesday, 1:00 p.m.
4. UH Seminars, Wednesdays, 3:30 p.m.
5. Perinatal Conference, Thursdays, 3:30 p.m.
6. Tumor Board, 1st & 3rd Fridays, 1:00 p.m.
7. Oncology Conference, 4th Friday, 1:00 p.m.
8. Visiting Professor Program

Kuakini Hospital
1. Hematology Rounds, Monday, 1:00-2:00 p.m.
2. Gastroenterology, Tuesday, 8:00-9:00 a.m.
3. Oncology Conference, Thursday, 8:00-9:00 a.m.
4. Endocrine Conference, 2nd Wednesday each month, 1:00-2:00 p.m.
5. Medical Statistics, 3rd Tuesday each month, 1:00-2:00 p.m.
6. Renal Conference, Wednesdays, 1:00-2:00 p.m.
7. Kidney Biopsy Conference, Tuesdays, 1:00-2:00 p.m.
8. Visiting Professor Program
9. G.I. Rounds, Tuesdays 8:00 a.m.
10. Infectious Disease Conference, Thursdays 1:00 p.m.

St. Francis Hospital
1. Medical Grand Rounds, Tuesdays (4th & 5th), 1:00-2:00 p.m.
2. Surgical Grand Rounds, Fridays (except 4th), 7:30-8:30 a.m.
3. Tumor Conference, Mondays, 7:30-8:30 a.m.
4. Visiting Professor Program

5. Clinical Pathology Topics, Mondays, 10:00-11:00 a.m.
6. Microslide Conferences, Tuesdays, 8:30-9:30 a.m.
7. Bone Marrow Pathology, Tuesdays, 2:00-3:00 p.m.
8. Basic Science Review & Research Conference, Thursdays, 1st & 3rd, 8:00-9:00 a.m.
9. Psychiatric Case Conference, Tuesdays & Fridays, 8:00-9:00 a.m.
10. Psychiatry for the Non-Psychiatrist, Tuesdays, 10:00-11:00 a.m.
11. Psychiatry Teaching Rounds, Thursdays, 9:00-10:00 a.m.
12. Medical Psychiatric Joint Teaching Rounds, Fridays, 11:00-12:00 noon
13. Surgical Mortality & Morbidity Conference, last Friday, 7:30-8:30 a.m.
14. Saturday Teaching Rounds, Saturdays (except 4th), 7:30-8:30 a.m.

Wahiawa General Hospital
1. Noon Seminars, 2nd Friday & 4th Tuesday

Wilcox Hospital (Lihue)
1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:30 p. m. & 2nd Wednesday, 12:30 p.m. of each month in the Mabel Smyth Building. Contact HMA Office as dates are subject to change.

SPECIAL EVENTS 1976

February 24	Minicourse on Pediatric Infection, at Wahiawa General Hospital Dining Room; 3½ hours credit. Contact the Medical Records Department at Wahiawa General Hospital for more information.
March 8-11	Obstetric Anesthesia Conference—Part II., at Sheraton Maui Hotel, Maui, HI, sponsored by the L.A. Obstetrical and Gynecological Society. For further information, contact: California Medical Association, Committee on Continuing Medical Education, 731 Market Street, San Francisco, CA 94103.
March 9-10	Regional Meeting of the American College of Physicians, in Honolulu. Contact: Bernard W.D. Fong, M.D.
April 7-9	Pediatric Gastroenterology, sponsored by Kauikeolani Children's Hospital; at Princess Kaiulani Hotel; 15 hours credit; fee: $35.00. For further information, contact Dr. S. L. Hammar at 531-3511. Advanced registration is required.
May 1-8	Management of the Surgical Patient at Mauna Kea Beach Hotel, Kamuela; sponsored by Stanford University School of Medicine; 27 hours credit; for more information, write: Edward Rubeinstein, M.D., Associate Dean, Postgraduate Medical Education, M121, Stanford University Medical Center, Stanford, CA 94305.
June 20-25	South Pacific Commission Cancer Seminar at the Pagoda Hotel, sponsored by the American Cancer Society. Contact: John R. Watson, M.D. or Kay VanSant at 531-1662.

The seminars on "Sexual Counseling: Office Management of Sexual Problems" sponsored by the ACOG and University of Hawaii will be held on the following dates: (20 hrs. credit)

February 23-27	October 18-22
March 22-26	November 22-26
April 19-23	December 20-24

April 11-16 Colposcopy—A Refresher Course, at Lahaina, Maui; 25 hours credit.

For further information, write to: American College of Obstetricians & Gynecologists, Department of Continuing Education, 1.E. Wacker Drive, Suite 2700, Chicago 1L. 60601

Programs sponsored by the University of Southern California:

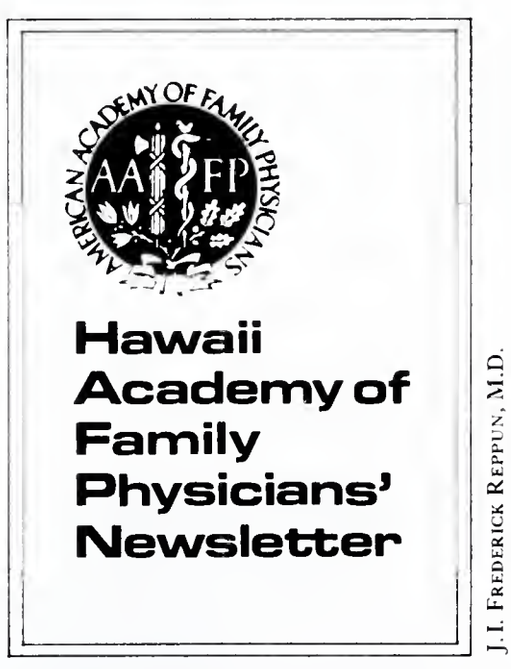
April 24-May 1	Chest and G.1. Radiology, at Royal Lahaina Hotel, Maui.
April 24-May 1	Pediatric Review, at Maui Surf, Maui.
April 26-May 1	Diagnostic and Therapeutic Skills, at Mauna Kea Beach Hotel, Kamuela, H1.
April 26-May 1	Emergency Medicine, at Kauai Surf, Kauai.
May 23-30	Nephrology, at Maui Surf Hotel, Maui.
June 13-20	Orthopedic Review, at Mauna Kea Beach Hotel, Kamuela.

For further information, contact: Phil R. Manning, M.D., Associate Dean, Postgraduate Division, USC School of Medicine, 2025 Zonal Ave., Los Angeles, CA 90033.

Visiting Professor Program:
Richard F. Bakemeier, M.D., Associate Professor of Medicine, University of Rochester School of Medicine, will be at Kaiser, Straub, Kapiolani, Kuakini, St. Francis (Category 1) and at Maui Memorial, Queen's and Tripler (Category 2), from February 23 through March 5.

OUT OF STATE

For information on any out-of-state programs or courses, refer to August 11, 1975 Supplement to JAMA or call the HMA Office.



NEWS of MEMBERS—Don Farrell, new chief of the department of Family Practice and Community Health at the

UH School of Medicine, announced that three second year residents in Family Practice will be accepted at the Kaiser Permanente Family Practice Residency program to start on 1 July 1976. He hopes that a full complement of 9 residents, three in each year of a three-year program, will be in effect by July 1978. **Les Vasconcellos** has returned to active participation in HAFP as a member of the Council (he and Madalin were present at the annual meeting dinner); Les has been reclassified Inactive by reason of not being in active practice since early 1975. **Verne Adams** of Pahala has asked to go back to Active Exempt status, as a "grandfather". **Doug Doyle** has been elected to Life membership. **Joe Lam** was honored in absentia at the annual meeting.

NECROLOGY—Long-time member **Bill Bergin** died on Christmas Day 1975. He was eulogized at the HAFP annual meeting in January. **Walter Ozawa** of Kailua, who, with **Bill Bergin,** joined AAGP in 1949 died on 22 January. A patient of the St. Francis Hospital Renal Dialysis Center for many months, Walter fell and broke his hip in December. He and Bill had both received their Fellow, AAFP degrees. Walter was Active Exempt. **Mrs. Genevieve Millard,** wife of member Bob, died after a long illness, on 18 December 1975. We offer condolences to the bereaved relatives.

GERIATRICS—An excellent all-day program at the Straub Clinic on 18 January put on by the Western Division, American Geriatrics Society, drew a relatively small crowd who resisted the Superbowl TV attraction that tied down 75-million American okoles to their seats (a good day for the "enemy" to start throwing their missiles at us, if they want to!). "Guidelines for the Management of Acute Problems of the Geriatric Patient" interested only four visible members of HAFP, maybe because it was only for E credit: **Tom Cahill, Doris Jasinski, Marc Shlachter** and **Fred Reppun.**

ADDENDUM—The **Bob Bensons** were also at the A.A.F.P. Chicago Scientific meeting.

ANNUAL MEETING—55 were present at the 24 January annual dinner meeting at the Willows, including guests of the chapter Bob Worth from the School of Medicine, and **Carl B. Hall,** President A.A.F.P. Carl installed the newly elected officers for 1976: **Don Farrell,** president, **Lincoln Luke,** president-elect, **Doris Jasinski,** secretary, **Fred Reppun,** perennial treasurer; three Councillors elected to 3-year terms: **Fred Lam, Tom Cahill,** and **Ron Hattis**; Councillor **Don Hall** to serve till 31 Dec 76, replacing **Bill Brownlee** who has moved away. Councillors whose terms continue are **Glover, Machigashira, P. Walsh, Vasconcellos** and **Yorioka.** Delegates **Felix Lafferty** and **Fred Reppun.** In between the delicious courses of the menu, there was a lot of spontaneous hilarity and good-natured ribbing that President Hall of Charleston, West Virginia, appreciated. His congratulating Felix Lafferty on his intention to run for the Board of Directors, A.A.F.P., elicited a petulant complaint from Dean-of-Members **Varian Sloan**; reminding those present that HE had been a member of the national Board 1962 to 1964! He was congratulated (and appeased).

Members will be receiving 1975 credit hour listings and the treasurer's report in the mail. PLEASE BE SURE TO REPORT YOUR HOURS TO OUR EXEC SEC ! ! !

LETTERS continued from page 37

The doctors use traditional Chinese methods developed over thousands of years and Western medicine. Certain characteristics of the Chinese methods are followed. The doctor looks at the patient, listens to what the patient says and to the voice, and feels the pulse.

"Barefoot doctors" were discussed. The name was originally applied to persons in the rural areas having a little understanding of how to aid sick people and walked barefoot to help the peasants. The city doctors organize teams to help the peasants in rural areas and train barefoot doctors. The barefoot doctor can also go to a city hospital to learn and train. There are over one million four hundred thousand barefoot doctors. They can perform minor operations, including hernia and appendicitis and pull teeth. Although there are midwives, the barefoot doctor can deliver babies. If faced with a serious emergency case the barefoot doctor can telephone a hospital or health center for information on how to treat the patient. A barefoot doctor will remain in that status regardless of how much training he has.

In answer to questions, the following was stated,

Doctors never see a venereal disease case so it is not taught in medical school.

Dogs carried so many diseases most were destroyed. A few dogs were seen in the rural area.

Seventy percent of children born deaf are cured by acupuncture.

Lung problems may be treated by Chinese or Western methods.

Rabies is rare. Malaria is rare in the North; there is some in the South, under control.

Education and training for doctors is three and one-half years, ten months' schooling and two months' vacation. There is too much time spent on theory from textbooks, such as forensic medicine. The best method to train a doctor is by experience.

A doctor should have the idea of serving the masses of the people and have a hearty feeling toward the patient.

Practial nurses receive the same pay as registered nurses. Doctors' salaries are based upon that of workers. There is much less mental illness than in the Western world. In Peking with eight million people there are only two small hospitals for such patients.

The Chinese doctors agree with the Western doctors they do not know the cause of psoriasis or a cure. They can give temporary relief.

In Sian, a general hospital was visited. It had 500 beds which were being extended to 600. Two thousand outpatients are treated every day. There are 570 medical workers and 16 departments. Medical teams are organized to work in rural areas. Regarding medicine, the doctor said "Chairman Mao says Chinese medicine is a great treasurehouse." The hospital now uses acupuncture as an anesthesia. 4,000 operations for different kinds of diseases had been performed with acupuncture as the anesthetic.

We were invited to watch the beginning of five operations using acupuncture as an anesthetic, and then each of us was to choose one operation to remain throughout the operation. They were (1) craniotomy, a peasant fell from a tree causing bone chips in the left side of his skull, plastic cup to be inserted; (2) removal of a peptic ulcer; (3) numbness of the face; (4) chronic sinus infection; (5) glaucoma. I watched the beginning of each operation and then remained to observe the entire eye operation, so a report could be given to my friend, Dr. Thomas Frissell. The operation on both eyes lasted twenty five minutes performed by two women doctors. I asked the 55-year old patient if she felt any pain and she said none.

The doctors decide whether to use acupuncture but the patient makes the final decision. The doctors told us it is not helpful to have a frightened patient for an operation.

From observation, women do not smoke; there is some smoking among men. Cigarettes cost 20 cents a package American money. The doctor stated they were aware of the alleged dangers of smoking; however, the people liked to smoke and there were more important problems to deal with at this time.

In Nanking we attended a school and saw the eye exercises required to be done in the classroom each morning taking about six minutes. It consists of slowly rotating the fingers over the eyebrows, the sides of the eyes, under the cheeks, and finally along the forehead. I obtained a chart of the eye exercises, which I have given to Dr. Frissell. At the end of the second period all students go outside the classroom and do ten minutes of physical exercises to phonograph music.

In Wushi we visited a commune. There are 74,000 communes each with an average of 40,000 people. There were 32 barefoot doctors. We also visited a Chinese herb plant. There were 300 workers making 70 varieties of Chinese medicines

in the form of tablets, pills, powders and concentrates. Having observed the Chinese herb stores in Honolulu, it was apparent that instead of mixing various dried herbs and telling the customer how much water to add and how long to boil the brew, the new method is Western in the form of concentrates, pills, etc. The bottles were colorful, with the prescription shown. We were shown a bottle containing a concentrate of ginseng with ground antler horn added and given assurance that it solved the male problem.

Ginseng appeared to be an ingredient in many of the bottles. We were informed if taken for a long period it is good for kidney disease, fertility, and to keep youthful. Two herb products are now exported, Coxcin, evergreen for long life, and Twelfth Red Liquid for rejuvenation. On the visits to several communes I watched prescriptions being filled and observed dried herbs were used and put in packages for the patients.

Since 1962 the price of herbs has been reduced four times and the present price is 67% of the 1962 cost. The State has fixed a 4% profit on sales.

Also visited was a workers' sanitarium in Wushi, located on a hill, with beautiful grounds overlooking a huge lake. We observed the patients doing exercises, using various machines, having acupuncture, and having hot plaster applied to various parts of the body.

Finally, a few observations of my own.

1. Although there are crowds of Chinese present on the streets and wherever anyone goes, I observed no obese females and only about ten obese males.
2. Females use no makeup and rub oil, either Chinese or Western, on their faces in the morning. I saw nobody with acne.
3. Females either have their hair cut at the neckline or have a pigtail.
4. Adults, male and female, wear a blue or gray coat with matching pants. No dresses or skirts were seen.
5. All school children wear colorful pants, jackets and socks. It is apparent the colors and the style of clothing will continue during maturity.
6. There is no sex education in the schools as the State wants to play down sex. Chairman Mao has stated that women should not marry until 26 and men until 28 and should abstain from sexual activity until they are married.
7. The women are following the request of Chairman Mao that they have only two children. The IUD is the most common method of control. A girl said that limiting the family gave more time to study and to assist other people.
8. No more than twenty people, adults and minors, were observd wearing glasses.
9. Everyone seen or spoken to had an expression of happiness in their eyes and on their faces, together with a warm, friendly greeting that was apparent although we were unable to communicate without an interpreter.
10. There is absolutely no food shortage in China and everyone appears healthy and well fed.
11. Through the interpreters everyone expressed love for the American people and looked forward to the time when there would be normal relations between the two countries.

Very truly yours,
MYER C. SYMONDS

To the Editor:

The recent report of 7 cases of pernicious anemia (incidence 3.2/100,000 population) in Japanese diagnosed at the Kuakini Hospital between 1973-75 (Fukunaga and Kaneshiro: Pernicious Anemia in Hawaii-Japanese, HWAII MED. J. 34:425,1975) recalls a brief survey to determine the incidence of pernicious anemia in the oriental and Caucasian population for a 5 year period between 1966-71 for 3 hospitals. The results revealed:

	No. of Cases			
	Kuakini Hospital	St. Francis Hospital	Queen's Hospital	Rate/ 100,000
Caucasian	1	4	6	4.4
Japanese	3		2	2.4
Chinese			1	2.5
Filipino			1	2.7

Several conclusions can be drawn:

a) The incidence for pernicious anemia in Hawaii Japanese for the period 1966-71 for 3 hospitals, although slightly less, is similar to the 1973-75 period from Kuakini Hospital (2.4 vs 3.2/100,000 population).
b) The incidence for pernicious anemia for Japanese, as well as Chinese and Filipinos, is still less than for the Caucasian population in Hawaii.
c) The 1966-71 survey confirms the recent Kuakini Hospital study that there is a higher incidence for pernicious anemia in Japanese in Hawaii compared to previously reported incidence in Japanese in general (2.4-3.2 vs 0.05/100,000 population).

Sincerely,
ROBERT T.S. JIM, M.D.



New Members



Minolu R. Cheng, M.D.
Hualalai Street
Kailua-Kona 96740
GENERAL SURGERY



William M. Hammon, M.D.
888 South King Street
Honolulu, Hawaii 96813
NEUROSURGERY



Debra Heverly, M.D.
P. O. Box 1266
Kailua, Hawaii 96734
EMERGENCY ROOM



Frank Roy Hurlbutt, M.D.
1697 Ala Moana Boulevard
Honolulu, Hawaii 96815
OBGYN



J. Crate Larkin, M.D.
305 Royal Hawaiian Avenue
Suite 206
Honolulu, Hawaii 96815
FAMILY PRACTICE



Eugene A. H. Magnier, M.D.
1697 Ala Moana Boulevard
Honolulu, Hawaii 96815
CARDIOLOGY



Kenneth K. Nakano, M.D.
888 South King Street
Honolulu, Hawaii 96813
NEUROLOGY



Jerry E. Prentiss, M.D.
888 South King Street
Honolulu, Hawaii 96813
ANESTHESIA

HMA Council Meeting

Special Council Meeting
December 12, 1975, 5:30 P.M.
Mabel Smyth Lanai

CALL TO ORDER

The meeting was called to order by President William W. L. Dang. Present were Drs. Calvin Sia, Grover H. Batten, Herbert Y. H. Chinn, Ann B. Catts, Albert C. K. Chun-Hoon, George Goto, Carl Lum, J. 1. Frederick Reppun, Walter W. Y. Chang (for Rowlin Lichter), Andrew Morgan (for Arnold Siemsen), Sakae Uehara, Verne Adams, and Douglas B. Bell 11; plus Mrs. Alice Tucker and Mr. V. Thomas Rice.

MINUTES

The minutes of the November 20, 1975 meeting were approved as circulated.

MISCELLANEOUS BUSINESS

A. Mr. Thorson announced a special tour to Europe and Russia sponsored by People to People, and scheduled for May 1976.

ACTION: **It was voted to give Mr. Thorson permission to solicit the membership regarding the trip.**

B. Candidacy of George Mills for AMA Board of Trustees: Dr. Dang informed the Council that Dr. George Mills plans to announce his candidacy for the AMA Board of Trustees.

ACTION: **It was voted to endorse the candidacy of George H. Mills, M. D. for the AMA Board of Trustees. It was further voted to write to the AMA delegates and state associations supporting his candidacy with a maximum budget of $500.**

C. *Cancer Commission:* Dr. Dang reported he had requested Dr. Grover Batten to continue as chairman of the Cancer Commission for 1976. Nominations were received from the Cancer Society, Medical School, and Department of Health as follows: Elmer Johnson (ACS), Christian Gulbrandsen (Uof H), and Kleona Rigney (DOH).

ACTION: **It was voted to approve the appointments to the Cancer Commission.**

D. *Report of the Auxiliary President:* Mrs. Tucker urged all HMA members to attend the forthcoming Sammy Davis show benefit for the Hawaii Medical Library on December 26. Tickets are available through the Honolulu County Medical Society Auxiliary.

E. *HMA Capital Fund Advance Plan:* A second draft of the Capital Fund Advance Plan was presented for Council review. A minor amendment was suggested.

ACTION: **It was voted to accept the plan as amended by deleting paragraph (c).**

WARD AVENUE SITE

An appraisal report covering the Ward Building was presented for Council review. A cash flow analysis including the rental income from tenants, the rental subsidy from HMA-HCMS and related organizations as well as expenses and mortgage obligations was also reviewed. An analysis of one of the fringe savings (Xerox machinery) was also presented. Complete details on all aspects of the proposal were presented by the realtor handling the transaction who also noted that the present owners of the building have agreed to work with the HMA in planning and directing the move.

ACTION: **It was voted unanimously to authorize the expenditure of up to $1 million for the purchase of the Ward Street building.**

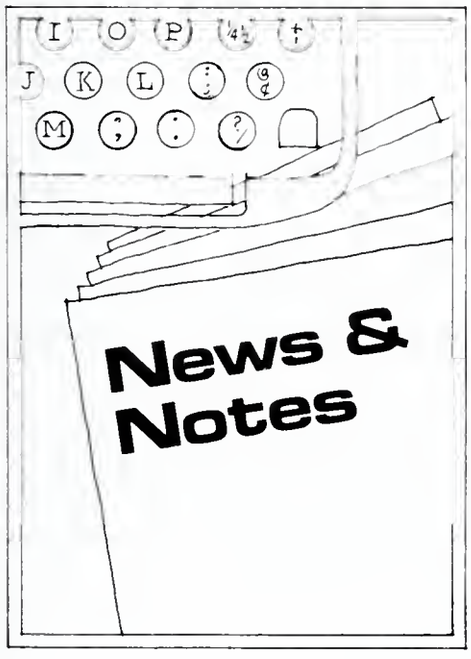
A meeting with the owners was scheduled for Monday, December 15, 1975, at 1:00 p.m. in the Mabel Smyth Conference Room. All members of the Council were invited to attend.

ACTION: **It was voted to direct the staff to look into all aspects of moving costs.**

ADJOURNMENT

The meeting adjourned at 8:15 p.m.

R. VARIAN SLOAN, M. D.
Secretary



HENRY N. YOKOYAMA, M.D.

Professional Moves

Our friend the oriental soothsayer consulted his zodiac and predicted the Year of the Dragon to be a prosperous one . . . It will be a happy year as well for *Homo Sapiens Medicus* who is so hard pressed by malpractice premium increases, rising overhead, mounting paper work, and constant pressure to keep fees down . . .

In January, internist **Henrietta Tompkins** announced that she will be on indefinite leave, and we learned that **Roger** and **Anna Maria Brault** have closed their Kailua office to go off to do some missionary work . . . In Honolulu, the Kaiser Group added GP **Steven Task,** internist **Nicanor Joaquin,** and neurosurgeon **Joel Feigenbaum.** Internist **Adelina de-Souza Matsui** opened at 419 Uluniu Street, internist **Carl Yorita** opened at Suite 801, Medical Arts Building, and orthopod **Thomas Nicholas Walinski** joined the Orthopedic Associates of Hawaii, Inc. at 1441 Kapiolani Blvd. On the Big Island, surgeon **David Campbell** joined the Hilo Medical Group and internist **Sukchai Sattapankiri** joined Kona Medical Associates.

The Health Department announced that **George Murdock,** chief of the school health branch and **Alice Broadhurst,** district health officer of Maui have resigned and **Verne Waite,** of the Waimea Clinic, will be the new chief of the hospitals and facilities branch.

Tom Thorson's Corner

Senator Foghorn, on the campaign trail, stopped to chat a bit with farmer Jones. Leaning over the fence, the Senator sez, "Well, Sam, you know I'm running for reelection . . . Can I count on your vote?" Sam kept munching on a straw in silent reflection . . . "Remember I got this road next to your farm paved . . . And I got your boy Roy appointed to West Point . . . And don't forget the loan I got you through the Federal Land Bank." "Yeah," drawled Sam, "But what have you done for me lately?"

Announcements

The 2nd Annual KCH fund raiser will be held May 8 at the Ilikai. Arrangements chairman **Ed Kagihara** is recruiting children ages 7 to 11 for the program. Allan and Juliet Grier who appear at the Halekulani are honorary chairmen. The program will feature a "Song About KCH," written by the Griers, as the prevailing theme . . .

Life in These Parts

We greeted **Jon Won** with "What's new?" and the Pacific PSRO director beamed happily . . . "President Ford's veto was overridden by Congress so PSRO is funded $47.6 million for fiscal 1976 . . . There's a good possibility that Pacific PSRO will go conditional by summer . . ."

A young UH law student, a patient, discussing living on a shoestring as a student, quipped, "But when I get to be a practicing lawyer, I'll be able to afford doctors." (contributed by **Fred Reppun**)

On Jan. 3, **J.K. Sims** of Queen's emergency service training program was conducting a free body surfing safety clinic at Makapuu Beach when two tourists were swept off by a rip current. J.K. gave the woman victim emergency treatment (the man victim did not require treatment) and continued with the clinic after she had been taken by helicopter to Queen's . . . **Jeff Sol** and **Dale Adams,** co-directors, conducted a free Medical Bicycle Clinic on Feb. 1, Sunday at the Waikiki Band Shell . . .

Merle McPherson, chief of the maternal and child health branch, reports that home births have increased in recent years. In 1968 there were 56 home births, and 127 in 1974. The State proposed midwife licenses to nurses who have graduated a school of nurse-midwifery approved by the American College of Nurse-Midwives. OB man **George Goto** says HMA has grave reservations about home deliveries. For safety's sake, George recommends that nurse-midwives deliver babies only in hospitals under MD supervision . . .

In the wake of the HEW's recommendation that physician advertising may reduce fees, HMA exec secretary **Tom Thorson** appeared on KGMB-TV "Cross Fire" and reported that HMA will continue to prohibit members from advertising because advertising might imply a service guarantee and could complicate malpractice problems.

Bernie Scherman of HEPA reported that his doctors' malpractice premiums jumped 300% and that HEPA will have to cut back on service at Hilo and Wahiawa hospitals . . .

Paul Gebauer resigned as City physician to protest the unfair and unfounded criticism of the City's ambulance service by KITV in early January . . . Mayor Fasi remarked, "If Gebauer does not reconsider his resignation, this community

will have lost the services of a capable, dedicated man and a fine human being."

Emmett Aluli, one of the "Kahoolawe Nine," was encouraged when President Ford wrote asking them not to go to Kahoolawe. The President wrote, "We understand your problem." Emmett remarked, "Someone in power is listening."

From Tom Horton's column we extract the following: "Sign in **Dr. Grant Howard's** office at Kaiser: 'Support Your Local Trial Lawyers—Send Your Child to Medical School."

Another item from Tom Horton's column: "Aina Haina pediatrician **Dr. Roy Kaye,** a Bronx boy who's lived in Hawaii for 14 years and therefore's become weather conscious, was visiting New York recently when he asked an old friend if the sky was always so gray. 'I don't know,' the New Yorker replied, 'Who looks?' "

Queen's Medical Center now has its $600,000 EMI-Scanner which authorities describe as "the most significant breakthrough in diagnosing brain disorders in 50 years." **F.B. Giles,** who will be running it, says the testing procedure will take less than an hour and most examinations can be done as an outpatient procedure. A recent report from Mayo reveals that "tumors were discovered in 25% of patients suspected of M.S., 21% of suspected strokes, 20% of convulsive disorders, 8% of patients with headaches and 7% of demented cases." **Will Henderson,** Queen's executive director, said that a major objective of the hospital in committing for the EMI Scanner was the improvement in cost to the patient. (Lower, we hope.)

Fred Gilbert, director of the Hawaii Breast Cancer Detection-Demonstration Project, reports that a new type of film (S0442) and an image enhancer (Rare Earth Screen) is being used to reduce radiation for X-ray mammograms by 88 to 97%. Fred reports that 57 breast cancers have been discovered with a possible another 15 positives, thus averaging 7 cases per 1,000 women without apparent symptoms (half of the cases were found by mammography alone . . .)

Elected, Appointed, Honored

On the cancer front, **Jim Mitchel,** elected vice president of the Big Island Cancer Unit in early November and killed Nov. 29 in the tidal wave and earthquake, was replaced by urologist **Manas Ghosh. Ed Dierdorff** was elected vice president of the Windward Cancer Unit.

On the community front, **Fred Reppun** was elected chairman of the Kahaluu Neighborhood Board in January . . . Fred announced, "While community groups would be free to go straight to the city on a particular issue, the issues really ought to be hammered out at the neighborhood board level." **Clagett Beck** and **Walter Quisenberry** were elected to the board of the Lanakila Crafts, Inc. **Angie Connor,** recently retired director of the Children's Health Services, was honored with the Edgar Doll Award for "almost single handedly steering the course of the progress that has been achieved in the fields of mental retardation and other handicapping conditions." **Nicholas Steuermann** of Hilo was appointed chairman of the Big Island division of the United Jewish Appeal.

On the academic front, **Richard Lam** was honored with a Silver Anniversary Citation by Creighton for "25 years of service to mankind and loyalty to the school." **Mark A. Wentworth** of Ewa Beach was named a fellow of the American Academy of Family Physicians . . . **Shun-Kwung Liao, Raymond Taniguchi** and **Harold Roger Netzer** were initiated as Fellows of the American College of Surgeons . . . And we proudly repeat, our illustrious HMA JOURNAL editor has been named president of the American Academy of Dermatology.

Personal Glimpses

Bob Rose has been hobbling around for several months with his left leg in a cast. We learned that Bob was on his 10 speed bike in a Kuliouou bikeway when he was hit by a car, fracturing both the tibia and fibula. He remarks ruefully with a painful grin, "Have to give it up . . . Too dangerous . . . Not the first time either . . ."

Kuakini Chief of Medicine **Mel Kaneshiro** has always been fascinated by spy plots in pulp magazines . . . With the Victorian flu rampant here, Mel theorizes that these epidemics may be part of a Soviet germ warfare plot wherein they shoot viral capsules into the jet stream which descends over the U.S. . . .

George Suzuki, our erstwhile tennis partner, showed us this astonishing message from his nurse as relayed by our nurse: "Dr. Yokoyama will be unable to play tennis today . . . Asked if you could *grab hold* of Florence." (Florence just happens to be Leabert Fernendez's attractive tennis playing wife.)

One noon hour, we took a leisurely drive up Tantalus Drive and found Charman Akina jogging up the top . . . A valiant figure clad in T shirt, white shorts and jogging shoes, pitted against a whole mountain of lush greenery . . . We envied him . . .

Miscellany

An 82-year-old Senator from the South proudly announced to his constituents at a rally that he was getting married to his 19-year-old secretary . . . There was a hushed silence instead of the cheering and accolades he had expected. Mystified, he turned to his aide for an explanation. The aide replied diplomatically, "We are fearful of the consequences." "Pshaw!" he replied. "If she dies, she dies . . ." (Jerome Marr, Honolulu Zoo Curator)

Strange As It Seems . . .(From a talk by zoo curator, Jerome Marr)

"There's an oriental myth that the rhino's horn is an aphrodisiac. The reason, as explained to me by an oriental zoo keeper, is that the rhino when copulating ejaculates continuously for 5 whole minutes . . ."

"The gorilla population in the world is rapidly declining and our only hope is to propagate the species in our zoos . . . One of the problems is that the zoo-kept gorilla does not know how to copulate. In England, they even showed the gorillas a movie of humans copulating, but the experiment failed miserably . . ."

"Did you know that the gorilla's penis is only 2 inches long?" We were astonished, but Jerry refused to comment whether this was a primary problem in the decline of the gorilla species . . .

"The cheetah did not propagate in the zoos till it was discovered that proximity of the male and female over a period was the deterrent factor . . . So now the cheetahs are separated so they can neither see or even smell each other . . . Then when they are brought together they copulate immediately . . . Now the cheetah population in the world zoos is growing by leaps and bounds . . ."

Hors De Combat

After he resigned as City & County Physician, **Paul Gebauer,** in a lengthy "Notice to the People of Honolulu," allayed the fears generated by the four day "barrage of derogations" of the city's ambulance service by TV Channel 4 in December. "Honolulu has always had good ambulance service, and I hold our present service in such esteem that I'm happy to accept the lumps from the cheap shots of a few malcontent individuals and those who wish to malign Mayor Fasi and all City operations . . . Some of the criticisms were warranted, most of them were ridiculous, not one was a 'real big thing' and none were really newsworthy . . . It is clear to me that of all the witnesses paraded by Mr. Rockwell, who expressed opinions, none of them have much of a grasp, or a real appreciation, of the manifold issues involved in offering a double-disciplined service . . . I'm sure they're not too informed on Union influence in an attendant's career ladder, or the mandatory composition of shift units, on medical liability and insurance, or on the regulation of medical procedures

Fast, fast relief for physicians.

We know you'll feel a lot better when your bills get paid promptly. You can get fast service from HMSA if you submit your claims promptly. It will not only keep your accounts current, the cash flow situation in your office will be a lot healthier. HMSA, Hawaii's non-profit medical plan, goes a long way in easing the pains of financial worry.

And we do a better job because of your help.



Hawaii Medical Service Association

. . . I hope Mr. Rockwell's star reporting and his impressive parade of witnesses regains him his center seat on the Channel 4 news team and relieves him of the drudgery of newsworthy movie reviews. If I get another 'return my call' message from him next Christmas Eve, I'll ignore it again."

Hawaiian activist **Emmett Aluli,** a Queen's Medical Center resident, returned to Kahoolawe with 3 others in mid January after spending two days there the previous week. Bombing was discontinued by the Navy when reports of their second landing were received . . . After being picked up by a TV news helicopter, Emmett expressed hopes of returning to the Navy's bombing target to celebrate his 32nd birthday . . .

We read with interest in Sylvia Porter's "Your Money's Worth," her summary of the new Michigan malpractice law and extract herewith therefrom: "As of Jan. 1, a new law will go into effect in Michigan which well may become the model for national legislation to end the spiral in medical malpractice insurance costs and thereby help curb medical costs for all of us . . . Even before the law is tested, close students of its provisions forecast that it will make medical history, alter the image of the medical profession, and do away with the spectacles of emotional trials before inexpert juries and the awarding of huge sums to patients, which end up primarily in the lawyers' pockets . . . In Michigan, of the malpractice premium dollar, 55 cents goes to the legal system, 23 cents to the patient, and the balance to the insurance company . . . It's even worse in some other states . . . Insurance companies have made it clear they detest the whole area of malpractice insurance . . . Juries continue to make financial awards that threaten to undermine the practice of medicine in the U.S. . . . The core of the new legislation—the importance of which obviously goes far beyond Michigan to touch the lives and pockets of all—is 'binding contractual arbitration.' It is an arrangement under which the patient signs an arbitration agreement . . . Under the Michigan law, a voluntary arbitrator will be selected to examine the validity of a complaint against a doctor or hospital . . .

What might be some of the results of the law? Awards need not be financial—a condition of settlement necessary to court jury system. Rather, an arbitrator might award surgery to remedy the patient's condition; or signal for convalescent care; or order a trust fund to continue for the life of the patient and then revert to the insurer.

A closer check will be made on the competency of physicians, giving the public the bonus of higher medical efficiency. Lists of doctors involved in 10 or more malpractice suits over a period of time are to be compiled; the appearance of these lists of doctors often involved in malpractice suits will trigger investigation.

A decided speedup will occur in the handling and the settling of malpractice suits." (Sounds fair enough)

Golf Quips

As we aligned our putt on the 7th hole green at Mid Pac for another go after our first putt had passed the hole by 4 feet, **Cool Wakai** muttered, "This is a real character builder . . ."

Then on the 8th hole, Cool pulled his drive into the trees on the left and hit two more trees very accurately on his next two shots. **Paul Tamura** remarked, "Tree-mendous shots!"

On the 19th hole, a lawyer friend stopped by to chat and Paul asked, "What's your handicap these days?" "My wife," was the prompt reply . . .

Golf Jokes (As told by our banker friend)

A neighbor watching Andy practicing golf shots in his backyard noticed something odd . . . "Why are you wearing two pairs of pants?" he observed . . . "I might get a hole-in-one," Andy replied.

Bill and Frank had invited Johnny to play for he was an easy mark. Sure enough, Johnny lost all bets and paid for the drinks and pupus on the 19th hole. As they parted, Johnny asked, "Can I bring a friend along next week?" "Sure," they said . . . So Johnny showed up with Joe, a gorilla, who walloped the first hole drive 400 yards onto the green, within 2 feet of the cup. Bill and Frank looked askance, conceded the putt and paid off . . . and inquired, "Incidentally, how does Joe putt?" Johnny smiled, "the same way he drives . . ."

Hors De Combat

Earlier in November, California attorney Fred Hiestand addressed the 6th Annual Emergency Medical Physicians Seminar and pointed out that "the problems of medical liability and malpractice 'are symptoms of a sophisticated society that has outsmarted itself' . . . The standards of medical care have consistently increased over the years and along with them the physician's liability . . . Technical and lay publications have led the public to expect near-miraculous results from medical treatment . . . There is a greater willingness on the part of juries to look critically at physician conduct . . . This again increases the standards of care and the liability of the doctor . . ." Later, **Russell Roth,** former president of the AMA, said the main task of the liability system should be to compensate the patient who suffers from a physician's incompetence, carelessness, or ineptitude . . . The issue is not how to make the physician immune from suit, how to preserve clientele for the legal profession, or how to make money for insurance companies . . . The present system does not fulfill its intended purposes . . . Out of every dollar collected in premiums, only 16 to 24 cents is paid out to the injured person for whose benefit the whole arrangement is presumed to exist . . .

In December, Argonaut Insurance Co., which covers 800 physicians in Hawaii, reported that effective Dec. 1 the average local increase will be only 20% higher than 1974 (as compared to the 300 to 400% increase in some areas on the mainland). Argonaut had not increased local premiums from 1971 to 1974 and in December of 1974, had increased the premiums 12% . The hospitals, on the other hand, had a

NOW LEASING

KAPIOLANI-CHILDREN'S MEDICAL OFFICE BUILDING

Excellent rent and terms. Includes air conditioning, private elevators, janitorial service, electricity and water. Ample parking available.

Grubb & Ellis

Grubb and Ellis Commercial Brokerage Company
900 Pacific Trade Center, Honolulu, Hawaii 96813
Phone (808) 531-4202

Knowing if a Personal Trust is right for you

...is a matter of knowing Bill Aull.



Bill is one of the most knowledgeable trust officers in the state. An expert — with eighteen years of professional experience at Hawaiian Trust, Hawaii's oldest and largest trust company.

His expertise, of course, is what makes him such a valuable trust officer. But he's also very much appreciated by his clients for two other reasons: the sincere personal interest he takes in everyone he talks with — and the amount of time he's willing to give to work out a problem or meet a need. Two qualities which also make him a popular, "get-results" President of the Honolulu Metropolitan YMCA.

In one visit, Bill can show you how a Personal Trust can free you from the time-consuming burdens of managing your stocks, bonds and other properties — by allowing Hawaiian Trust to manage them for you. But never think that you automatically lose control of these assets because you assign Bill, or one of our other personal trust specialists, to handle them for you.

You can retain as much administrative control, contact and responsibility as you wish. You just don't have to bother with the day-to-day details.

Your trust arrangement works the way you want it to. And most important, all of your investments are handled by professionals — people who are the best in their business. Bill knows. He is a member of our company's Investment Policy Committee.

If, after talking with Bill, you find you would benefit by establishing a Personal Trust, he can make all the arrangements. Discuss it with your attorney. Then call Bill Aull at 525-6575. He'll be happy to discuss your plans with you at your convenience.

Trust Hawaiian to make it easy.

Hawaiian Trust Company, Ltd.

Financial Plaza Of The Pacific, Honolulu, Hawaii 96813
In Wailuku: Wailuku Town House
In Hilo: Kaiko'o Mall



Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct nontherapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

P·M·A
Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005

300% increase earlier in 1975, but that too was one of the lowest increases for hospitals (Lucky we live Hawaii?)

Oncology Dialogue

A 59-year old Chinese woman, who had postop radiation therapy 26 years ago for endometrial CA, was admitted for intermittent obstipation and diarrhea of 1 year duration. Biopsy of a rectosigmoid lesion 7-8cm from the anal verge showed adeno CA, Dukes Type B. Moderator **Noboru Oishi** asked, "Tell us about Duke's Type B. There has been a change in thinking on survival." Pathologist **Grant Stemmerman** was not optimistic: "The original Duke's classification is through the muscularis. I use the original . . ." Noboru: "Let me ask about radiation carcinogenesis, i.e., low doses, prolonged, vs. high doses, short courses . . ." Stemmy: "Don't ask me . . . Ask your ionizing specialists . . ."

Radiotherapist **Carl Boyer** elucidated: "It happens both ways . . . And when it occurs 15 or 20 years later, I'll be the last one to argue . . ."

Noboru: "Can you tell histologically whether or not it is radiation carcinogenesis."

Stemmy, being unusually reticent: "No."

Immunologist **Ben Gordon** offered: "Here's where CEA will be of value. If it's 100, then we know there's significant tumor left. It is almost 100% positive in colon-rectal CA . . . I get requests to rule out, but CEA never rules out . . ."

A 39-year old man had a total thyroidectomy for papillary adeno CA of the isthmus and the adjacent right lobe. Stemmy made a speech: Of all the CA's, I would like to have a thyroid CA. 25% of the Japanese have occult papillary CA. There is no age discrimination in this tumor . . . The implication of this in my mind is that the treatment of choice is minimal treatment: excision and hormonal therapy. I don't like to see bilateral thyroidectomy and radical neck dissection done . . ."

Locker Room Jokes

Kimo and Manuel decided to join up in the new volunteer army . . . As they lined up for their uniforms, Manuel admitted, "I don't know my clothes sizes . . . Ma used to buy everything . . ." Kimo reassured him: "Don't worry . . . You look one size bigger than me . . . When I yell out my size, you just yell one size larger . . ." Manuel got the picture . . . They got to the shirt counter . . . Kimo yelled out, "Neck 15, sleeve 32" . . . Manuel next in line yelled, "Neck 16, sleeve 33" . . . They got to trousers, and Kimo yelled, "Waist 32, length 34." So Manuel yelled, "Waist 33, length 35" . . . The shirts, trousers, and shoes fit perfectly . . . Then they reached the cap counter . . . Kimo yelled out, "Size 6⅞" and Manuel followed suit with "9-10-11" (Also told by George Suzuki)

Physicians Speak Up

Rowlin Lichter took to task a *Star Bulletin* editorial on health maintenance as follows: "Your inferences are almost unconscionable . . . It would appear from the way you have written that the AMA is against health and health maintenance . . . We doctors are absolutely and dedicatedly for health . . . Maintaining good health is the primary aim of every practicing physician . . . The real deficiency, however, on health maintenance is you and those about you . . . When was the last time you had a physical? . . . When was the last time you or your co-workers left the car at the party and took a cab home or went home with somebody else when they had been drinking? . . . What about good daily exercise? . . . I could go on and on with things like reading labels on medicines, exposure to the elements, proper clothing, and so on . . . But, all in all, the basic problem with health maintenance is not government, not a nefarious plot by the AMA or the HMA, a battle between Kaiser and HMSA or between medicine, dentistry, chiropractic and veterinary surgeons . . . The basic problem is the organism whose health we are trying to maintain . . . The organism who shouts and demands health maintenance while he destroys that God-given state with self-administered and group-administered physical and mental abuses . . .

"When people support the American Cancer Society with the money that they would normally spend on cigarettes, when they learn to conserve energy and fuel by reducing the amount of food they gorge themselves with, when they take time out for rest and relaxation, when they learn to exercise regularly and leave their cars at home and when they stop polluting the air they breathe, then health maintenance organizations may have a chance to work. Get to the basis of the problem." (That's laying it on!)

Robert Clingan complimented the *Advertiser* editorial, "Emergencies, Malpractice." "This is not a problem which concerns just physicians, lawyers and insurance companies, but all the people who require medical care. They ultimately must bear the financial burden, if not the catastrophe of a lack of adequate medical care . . . Since all the people of Hawaii will be paying the increasing cost of this insurance coverage for physicians and hospitals, they must be involved in the solution of the present crisis. They may contribute to the solution by urging their legislators to take appropriate action before the crisis becomes a catastrophe. The people can effectively influence the appropriate legislation only if they are adequately informed of all aspects of the problem . . . The press is in a unique position among the media in its ability to provide in-depth background information as well as thorough up-to-date coverage of such a complex issue . . . The broadcast media frequently provide only superficial coverage and usually only the most sensational aspects . . . Hopefully with the 'informed consent' of the people of Hawaii, an equitable solution to the present crisis will be found . . . A solution which will be in the best interest of all the citizens of Hawaii."

Plastic surgeon **Jim Penoff,** pathologist **Jim Navin** and surgeon **John Balfour** were on a half-hour question and answer panel following the 1 hour documentary, "Why Me?" on breast cancer shown on KHET TV in December.

Director **Fred Dodge** wrote a lengthy reply to an Elizabeth Bell article critical of the Waianae Health Center. Fred wrote: "Because of the dozens of inaccuracies, what could have been an enlightening article on different types of medical practices and philosophies has failed . . . We have a capable, conscientious and varied staff (including part-time consultants) serving over 60 patients (not 44) per day . . . We are different . . . We are the only non-profit community based Health Center in Hawaii . . . We use the problem-oriented medical record . . . It certainly takes more effort on the part of our primary care providers and staff . . . We feel that the benefit to our patients is worth this added time and effort . . . Our philosophy is to work with patients, stressing as much as possible, health education and preventive medicine . . . We aim to be a resource for the patient and not vice versa . . . Concerning the costs: The center and its concept as stated above, may be considered an experiment . . . I feel we will succeed . . . Not that ours is the only way medicine must be practiced: however, it is one of the alternative ways . . . I know of no worthy experiment which has not had its problems and difficulties . . . All we are asking for is a chance, and then let the people of Waianae decide—as they ultimately will . . . Lastly, I strongly feel that our tax money is better spent—even experimentally—to attempt to preserve life rather than destroy it . . . Since Mrs. Bell and several others mentioned in her article are so opposed to waste of tax money, I invite them to join me in opposing the use of our resources for war and destructive purposes, which far outspends by billions that used for life-sustaining purposes. Perhaps, then, even with our different views, we can work together to truly serve all people . . ."

Willis Butler criticized the hypocrisy of editorializing for strong gun controls and advertising cigarettes at the same time: "No knowledgeable person disagrees with the Surgeon General's conclusion that cigarette smoking as a cause of lung cancer 'far outweighs all other factors' (No knowledgeable and honest person, I should say) . . . The hypocrisy and intellectual dishonesty is bad enough from any point of view . . .

PreSun

(5% PABA LOTION)

may help prevent harmful effects of the sun such as premature aging of skin and skin cancer.*



*Information on file at Westwood Pharmaceuticals Inc.

WESTWOOD
PHARMACEUTICALS INC.
Buffalo, New York 14213

©1974, W. P. Inc

The cynicism reaches its lowest depth in the deliberate appeal of cigarette ads to young people still in the stage of habit formation and vulnerable to images of phony glamour . . . Perhaps you should consider introducing the word into your masthead. How does "The Honolulu Panderer' strike you?"

David Sears of Kapaa was critical of Kauai County officials meeting with promoters at Princeville to discuss a projected 90,000 population for Kauai: "Sunshine bill, open government, free two-way communication between our government and the citizens who pay their salaries . . . Are these just catch phrases to get elected? . . . Nine out of ten of the people I meet are opposed to further unlimited hotel expansion . . . Citizens, unite! Help save Kauai . . . Tourists come here because Kauai is different . . . Help keep it that way."

In a Pat Hunter article, **John McDermott,** professor of psychiatry at UH Med School, estimated 200,000 and 300,000 of the nation's school children to have MBD (minimal brain dysfunction) and are being treated with drugs to alleviate behavioral symptoms. John agreed that pills will not replace parenting and teaching, and no child should be placed on medication until a complete medical workup, including neurological testing has been done. John said, "However, there are certain target symptoms that medication can help—short attention span and hyperactivity . . . The Porteus maze test—a test for intelligence developed here in Hawaii by **Dr. Stanley Porteus**—has turned out to be the best test of the drug's effectiveness . . ."

Daniel Ponce, psychiatrist with the Mental Health Division of the Health Department, also feels that drugs are beneficial to children who are carefully tested and where the diagnosis of MBD is confirmed. Daniel guesses that if data were available, the numbers of children labeled hyperactive and the number given medication would be the same, thus tripling the known figure of 109 treated with drugs out of 280 estimated from health data collected in the 1974-1975 school year on 63,000 children.

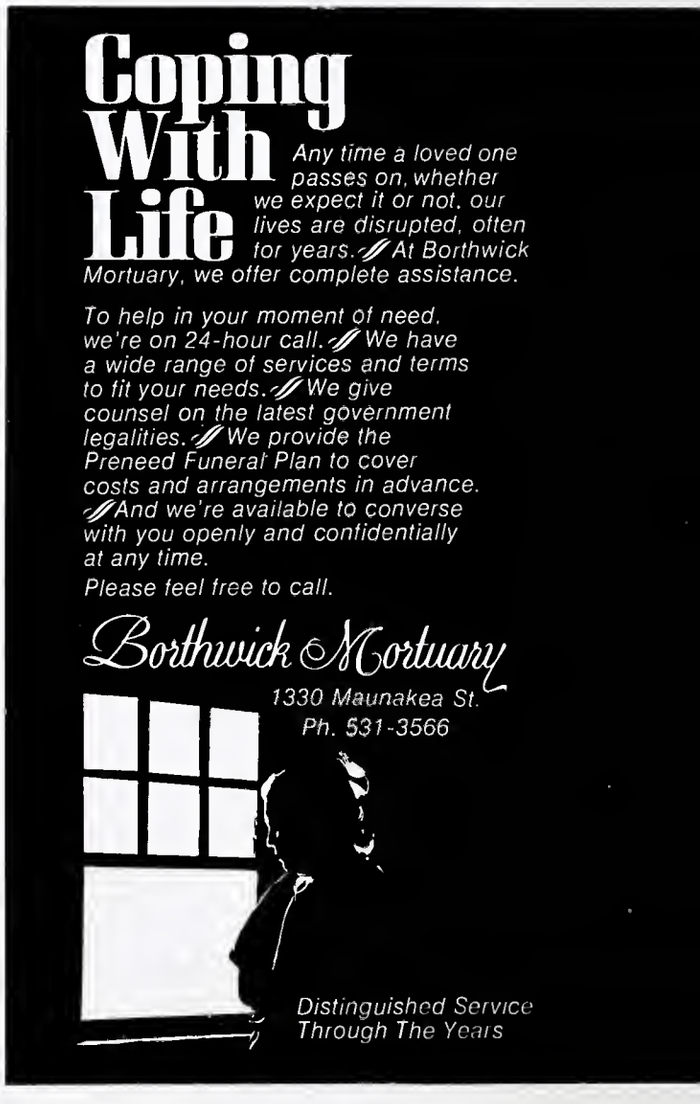
John and Daniel were refuting the claims of neuropsychologist **Herbert Grossman,** visiting professor in special education at the UH, who believes that Ritalin and Dexedrine do not do enough good to warrant widespread use. Grossman's own study of MBD children treated with drugs showed that only 5 to 10% had dramatically good results, and says: "Medication is no substitute for special teaching . . . There are no ABC's in drugs . . . What I'm concerned about is that drug therapy may be used as a substitute for proper educational services instead of used in conjunction with special teaching . . . Many doctors are being pressured into prescribing drugs on the basis of teachers' and parents' perceptions of the child's behavior rather than on their own direct observation."

Musical Critics?

From "Musical Notes" by Janos Gereben, we note that Allan Barnes from the Dept. of OB GYN, Johns Hopkins School of Medicine, made the following astute observations re the performance of La Traviata coming to our BMC: "The physician who attends La Traviata is likely to be disturbed by the practice of medicine shown in the last act . . . The heroine, Violette Valery, is dying of tuberculosis. In the first place, she is far too buxom and stout to have terminal pulmonary disease. Dr. Grenvil arrives carrying flowers and proceeds to sit familiarly on her bed. After these lapses in professional behavior, he fails to feel her pulse, or listen to her lungs or even to take her temperature. He assists her in getting out of bed—admittedly it is difficult to hit high C recumbent beneath a feather bolster, but this is no way to treat serious pulmonary tuberculosis. Finally, he kisses Violetta on the forehead (questionable ethics and very bad hygiene), then he announces to the maid Annina (in a fine bass which surely can be heard by the patient) that death is only a matter of hours away. Before the end of the act, Violetta, who has been singing powerfully about her lost loves and past life, collapses and takes eight bars to die, whereas a major pulmonary hemorrhage would have carried her away in two measures."

Our "Angels"

	Page
Ayerst Laboratories *Mysoline*	38, 39, 40
Bio-Science Laboratories *Pathology Associates*	69
Borthwick Mortuary	68
Grubb and Ellis	62
Hawaii Bancorporation Leasing, Inc.	74
Hawaii Medical Service Association	61
Hawaiian Trust Company, Ltd.	63
Eli Lilly and Company *Kefzol*	44
McNeil Laboratories, Inc. *Tylenol*	36
PVO International, Inc. *Saffola*	73
Pharmaceutical Manufacturers Association	64, 65
A.H. Robins Company *Donnagel/Robitussin*	41, 42, 43
Roche Laboratories *Dalmane*	70, 71, 72
Valium	34, 35
Westwood Pharmaceuticals, Inc. *Presun*	67



We're the only lab in the islands affiliated with Bio-Science.

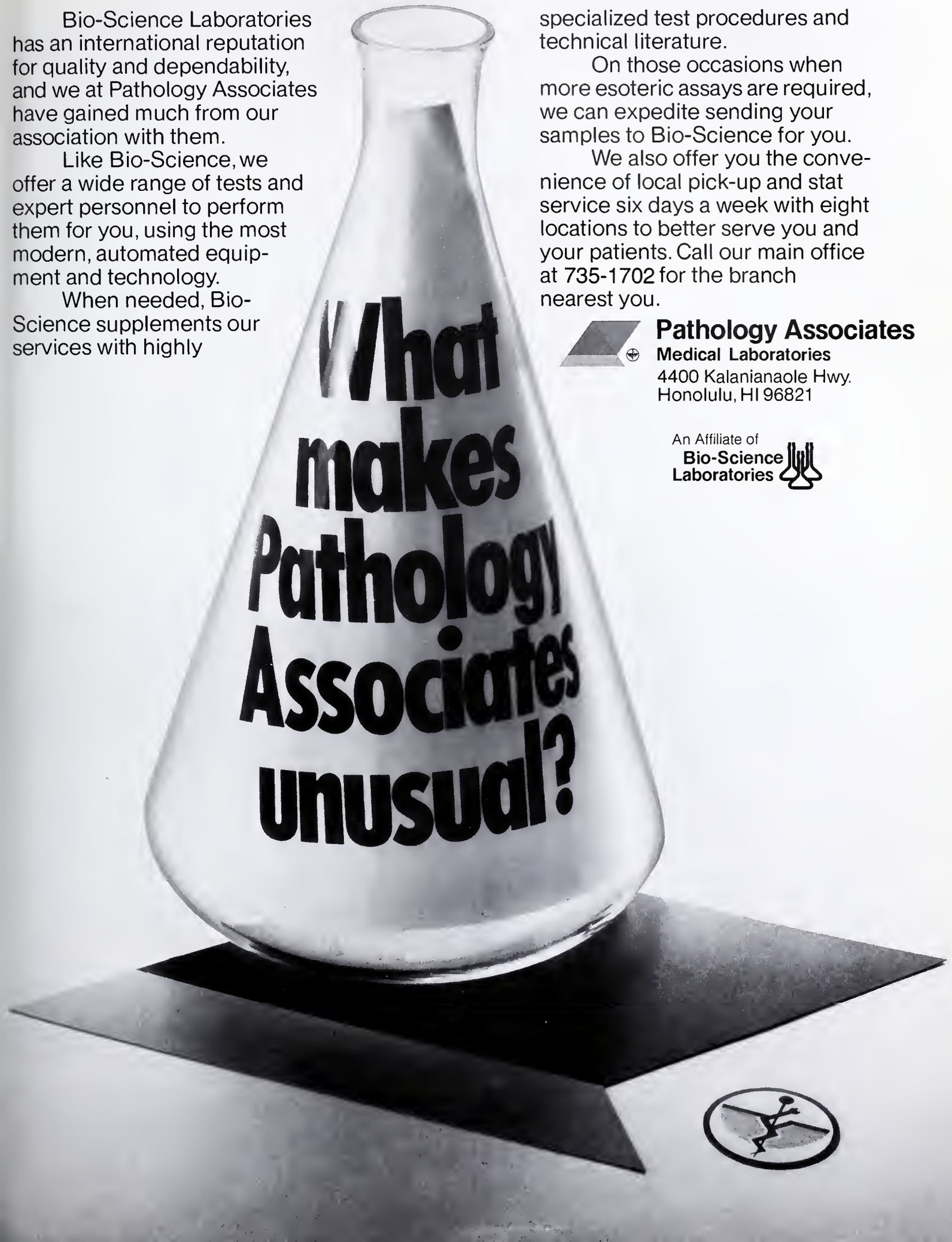
Bio-Science Laboratories has an international reputation for quality and dependability, and we at Pathology Associates have gained much from our association with them.

Like Bio-Science, we offer a wide range of tests and expert personnel to perform them for you, using the most modern, automated equipment and technology.

When needed, Bio-Science supplements our services with highly specialized test procedures and technical literature.

On those occasions when more esoteric assays are required, we can expedite sending your samples to Bio-Science for you.

We also offer you the convenience of local pick-up and stat service six days a week with eight locations to better serve you and your patients. Call our main office at 735-1702 for the branch nearest you.



Pathology Associates
Medical Laboratories
4400 Kalanianaole Hwy.
Honolulu, HI 96821

An Affiliate of
Bio-Science Laboratories

Effectiveness across the spectrum of most common forms of insomnia

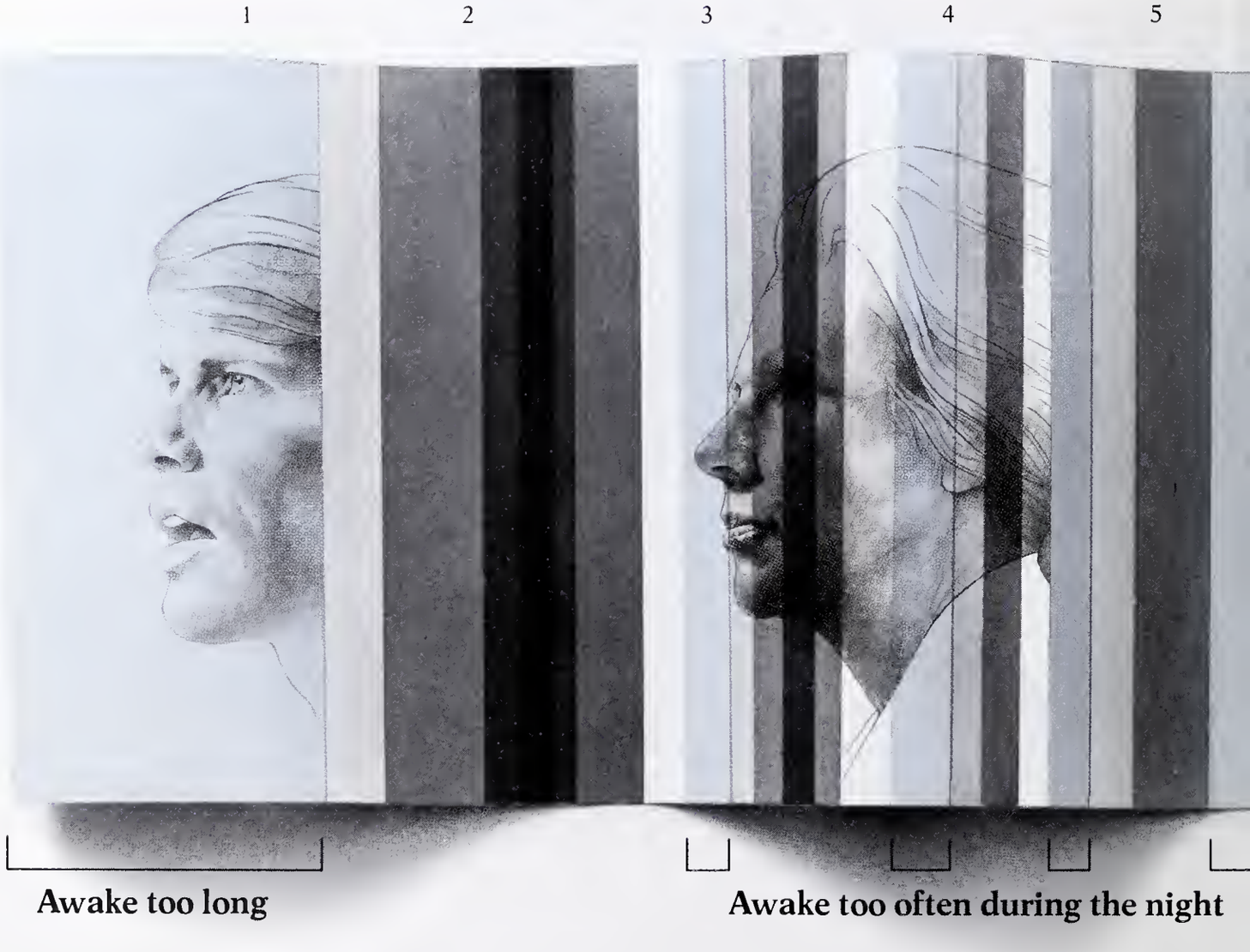
Awake too long, awake too often, awake too early...

These are the most common forms of insomnia, and may occur singly or in any combination. The night of troubled sleep depicted here comprises all three types. As the night progresses from left to right, each sleep stage is identifiable by its own shade of gray. Blue represents "Awake."

As you can see, this hypothetical "patient" takes well over an hour to fall asleep, awakens several times during the middle of the night and awakens too early in the morning.

Sleep Stages

- Awake
- REM
- Stage 1
- Stage 2
- Stage 3
- Stage 4



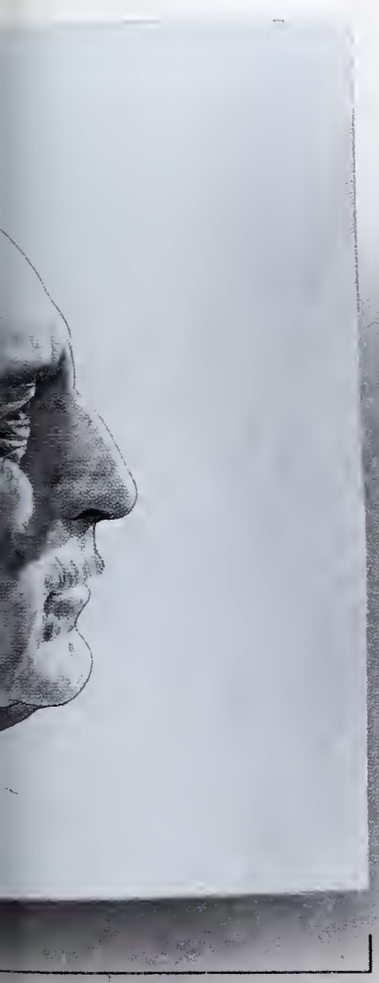
The insomnias most often occurring in young and older adults

For patients with trouble falling asleep (common in young adult insomnia patients), Dalmane (flurazepam HCl) 30 mg provides sleep within 17 minutes, on average. For those with trouble staying asleep or sleeping long enough (common in those over 50), Dalmane offers increased total sleep time with fewer nocturnal awakenings. These clinical results were demonstrated in studies conducted in four geographically separated sleep research laboratories.[1-4]

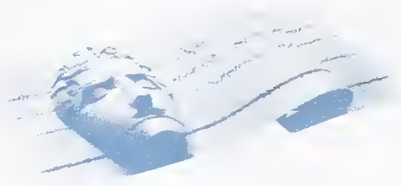
The relative safety of Dalmane (flurazepam HCl) is well documented

Dalmane (flurazepam HCl) is relatively safe and well tolerated; morning "hang-over" has been infrequent. The usual adult dosage is 30 mg; in elderly or debilitated patients, limit initial dosage to 15 mg to preclude over-sedation, dizziness or ataxia. Caution patients about possible combined effects with alcohol and other CNS depressants.

Broad-spectrum medication for the most common forms of insomnia



Awake too early



Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.*— usual adult dosage
(15 mg may suffice in some patients).
One 15-mg capsule *h.s.*— initial dosage for elderly or debilitated patients.

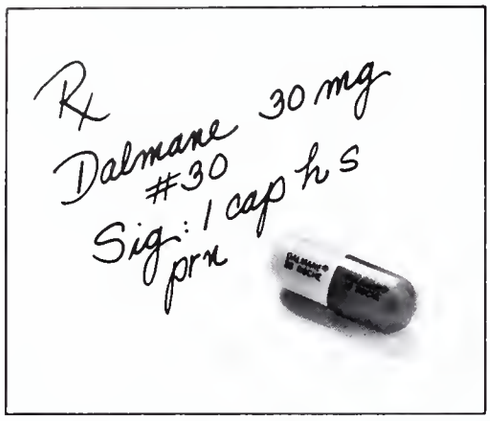
- induces sleep rapidly
- reduces nighttime awakenings
- lengthens total sleep time

ROCHE

Please see following page for a summary of complete product information.

Broad-spectrum medication for the most common forms of insomnia

Dalmane®
(flurazepam HCl) ℞IV



Objectively proved in the sleep research laboratory, Dalmane

- □ induces sleep within 17 minutes, on average
- □ reduces nighttime awakenings
- □ provides 7 to 8 hours sleep, on average, without repeating dosage

Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

REFERENCES:

1. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
2. Frost JD Jr: A system for automatically analyzing sleep. Scientific exhibit at the 24th Clinical Convention of the American Medical Association, Boston, Nov 29-Dec 2, 1970; and at the 42nd annual scientific meeting of the Aerospace Medical Association, Houston, Apr 26-29, 1971
3. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
4. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ



ROCHE

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

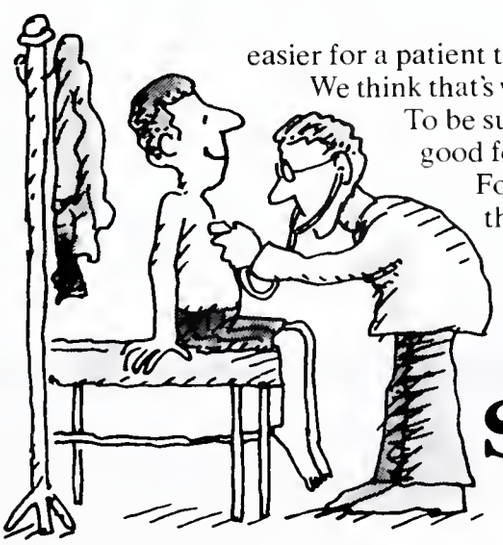
Saffola® is higher in polyunsaturates than Fleischmann's, Imperial or Mazola.



Shouldn't that difference make a difference in what you recommend?

Your patients on modified fat diets can't do better than Saffola. Of the leading margarines, Saffola is highest in polyunsaturates. And no other margarine is lower than Saffola in saturated fats. Because Saffola contains safflower oil—one of nature's most perfect foods. Safflower oil is higher in polyunsaturates than any vegetable oil, including corn oil. But to your patients, Saffola's good taste is just as important as Saffola's nutrition. The flavor makes it easier for a patient to follow a low cholesterol diet.

We think that's why Saffola is worth recommending. To be sure your patients are eating what's good for them, and enjoying it.

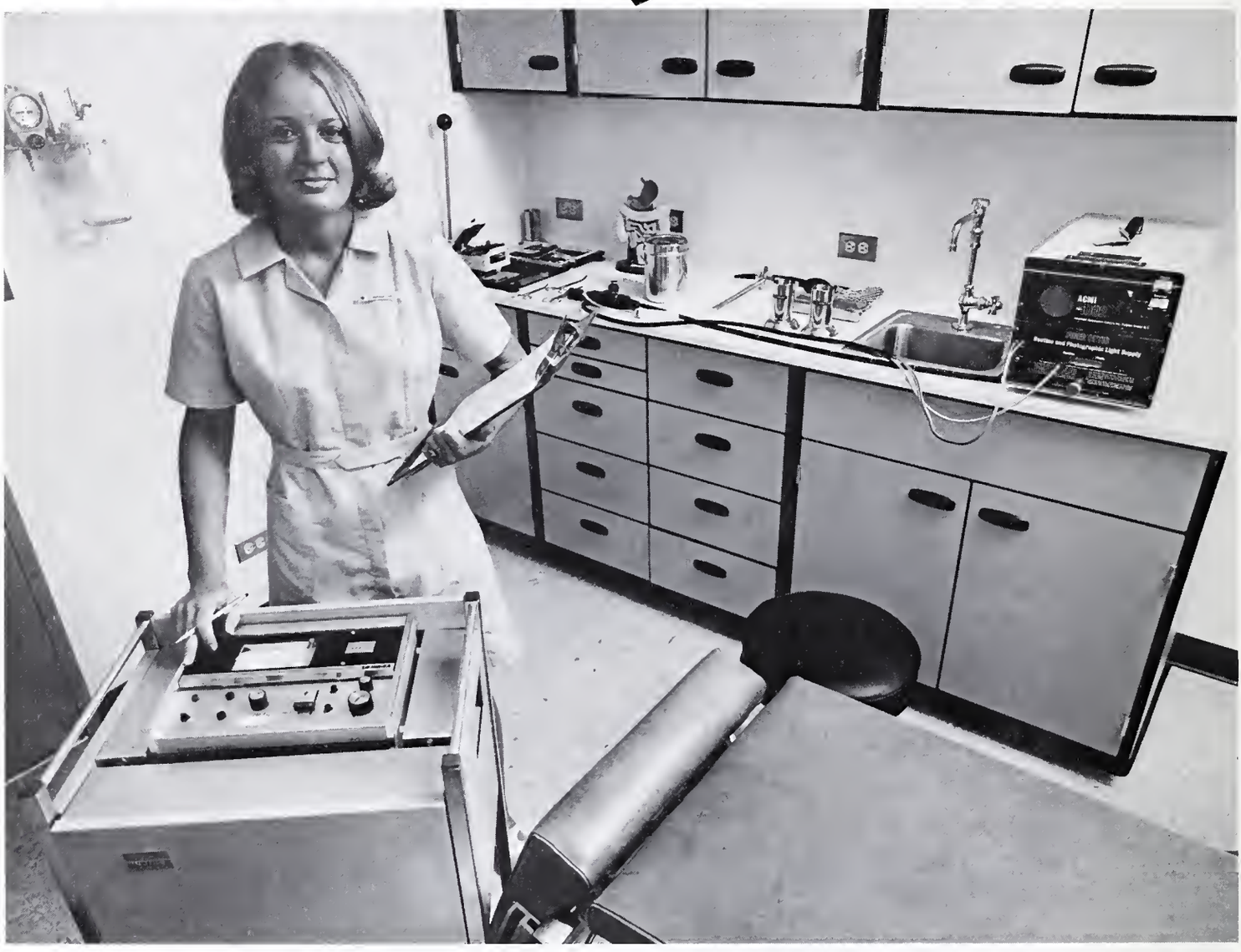


For comparative information about the nutritional benefits of Saffola, write Consumer Products Division, PVO International Inc., World Trade Center, San Francisco, 94111.

Saffola



WHY LEASE MEDICAL EQUIPMENT?



It may be just what the doctor should order. Take a moment and look into it.

Why lease? Well, it has to do with money. Your money. We're Bancorp Leasing, and we're an affiliate of Bank of Hawaii. Together, we know a lot about how to make your money work for you. When you lease your medical equipment, you've got your hard-earned money available for more pleasant or profitable investments.

Leasing is also a tax deductible expense. Leasing through us leaves you and your staff free of the paper work involved in equipment acquisitions. It's our worry.

Give us a call at 537-8810. If you like, we can make an appointment to come out and see you. There's no obligation. Except our obligation to help you get as much out of your capital as possible.

HAWAII BANCORPORATION LEASING, INC.

An affiliate of Bank of Hawaii
P. O. Box 2900, Honolulu, Hawaii 96846 / Phone 537-8810
The answer to all your leasing questions.

MARCH, 1976
VOL. 35, NO. 3

Hawaii Medical Journal

CONTENTS

Distribution of HL-A Antigens in Korean Population 83
Jin Pok Kim, M.D., Joon H. Hong, M.D., and Young K. Paik, M.D.

Continuing Medical Education 92

Editorials 87

Hawaii Academy of Family Physicians' Newsletter 91

HMA Council Meeting 88

HMA Newsletter 86

Letters to the Editor 79

New Members 88

News and Notes 94

LIBRARY
U.C. SAN FRANCISCO
APR 19 1976

The Library
Acquisitions Division SP
University of California, San
Francisco
San Francisco California 94143

Both often



Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

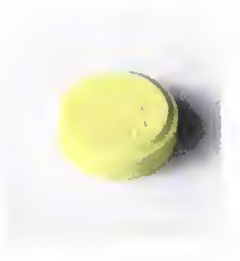
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium®
(diazepam) Ⓡ IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Both often



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

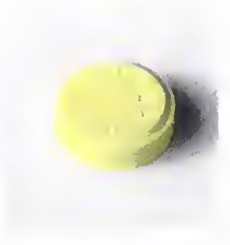
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequen and/or severity of grand mal seizures m require increased dosage of standard an convulsant medication; abrupt withdraw may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuanc (convulsions, tremor, abdominal and mu cle cramps, vomiting and sweating). Kee addiction-prone individuals under carefu

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium®
(diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

A NON-ASPIRIN ALTERNATIVE TO COMPOUND ANALGESICS

Documented potency: Double-blind clinical studies[1,2,3] demonstrate the efficacy of TYLENOL® acetaminophen Extra-Strength capsules (500 mg.) in the control of moderate to severe pain.†

No aspirin side effects: Unlike most compound analgesics, TYLENOL Extra-Strength capsules contain no aspirin; they therefore minimize the risk of side effects often associated with aspirin, such as gastric irritation, hemostatic disturbances and allergic reactions.

So when your patients with minor conditions need greater analgesic strength than that provided by regular doses of the mild analgesic products, recommend or prescribe TYLENOL Extra-Strength capsules.

1. Hopkinson, J.H. III, et al.: Curr. Ther. Res. *16*:194 (Mar.) 1974.
2. Berry, F.N., et al.: Curr. Ther. Res. *17*:361 (Apr.) 1975.
3. Smith, M.T., et al.: Curr. Ther. Res. *17*:452 (May) 1975.

Precautions and Adverse Reactions: If a rare sensitivity reaction occurs, the drug should be stopped. TYLENOL® acetaminophen products have rarely been found to produce any side effects.

Available in bottles of 50.

†Episiotomy was used as a model to evaluate analgesia.

Recommend or prescribe 2 caps t.i.d. or q.i.d.*

*No more than a total of 8 capsules in any 24-hour period.

© McN 1976

McNEIL McNeil Laboratories, Inc., Fort Washington, Pa. 19034

TYLENOL® acetaminophen EXTRA-STRENGTH CAPSULES 500 mg.



HAWAII MEDICAL JOURNAL

Published Monthly by the
HAWAII MEDICAL ASSOCIATION
(Incorporated in 1856 under the Monarchy)
510 S. Beretania St., Honolulu, Hawaii 96813

EDITORS

Editor, HARRY L. ARNOLD, JR., M.D.
News Editor, HENRY N. YOKOYAMA, M.D.
Assistant Editor, DORIS R. JASINSKI, M.D., M.P.H.
Contributing Editor, ROBERT H. MOSER, M.D.
Contributing Editor, J.I. FREDERICK REPPUN, M.D.
Book Review Editor, WINFRED Y. LEE, M.D.
Executive Editor, PAUL STEWARD

OFFICERS

President, WILLIAM W.L. DANG, M.D.
President-Elect, CALVIN C.J. SIA, M.D.
Past President, WINFRED Y. LEE, M.D.
Secretary, R. VARIAN SLOAN, M.D.
Treasurer, GROVER H. BATTEN, M.D.

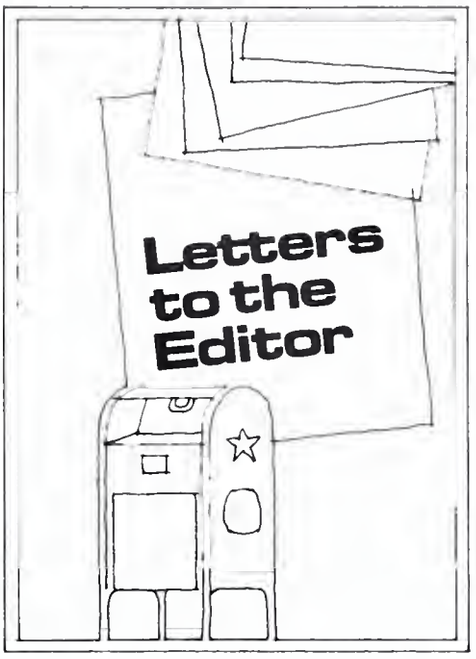
County Presidents

Hawaii, KENNETH HUGHES, M.D.
Honolulu, DOUGLAS B. BELL, II, M.D.
Kauai RIEAZI REMITIO, M.D.
Maui, CLIFFORD MORAN, M.D.
Delegate to AMA, GEORGE H. MILLS, M.D.
Alternate Delegate to AMA,
HERBERT Y.H. CHINN, M.D.

Advertising Representatives
National:
HAWAII MEDICAL ASSOCIATION
510 S. BERETANIA STREET
Honolulu, Hawaii 96813
Phone (808)536-7702
Honolulu:
LILITH JURRY, Phone 946-0053

THE JOURNAL may not be held responsible for opinions expressed in papers, discussions, communications, or advertisements. The advertising policy of the HAWAII MEDICAL JOURNAL is governed by the rules of the Council on Drugs of the American Medical Association. The right is reserved to reject material submitted for editorial or advertising columns. All material for publication must be in the hands of the editor on or before the 10th day of the month preceding publication date. Reprints of original articles will be supplied at actual cost. A reasonable number of illustrations accompanying an article will be accepted for printing. The right is reserved to ask the author to bear cost of these when it is found necessary to do so.

Copyright, 1976 by the Hawaii Medical Association, Honolulu, Hawaii. 2nd class postage paid at Honolulu, Hawaii. Office of Publication: Mabel L. Smyth Memorial Building, 510 S. Beretania St., Honolulu, Hawaii 96813.



To the Editor:

I read an item from your "News and Notes" column in the January edition of the HAWAII MEDICAL JOURNAL concerning the high incidence of TB in Hawaii.

In our practice at the Hamakua Infirmary in Honokaa, we are continually picking up cases of TB by skin testing the new immigrants from the Philippines. Oddly enough, there is no requirement for TB testing either before these people leave the P.I. or when they arrive here. Perhaps if something were done about this unfortunate situation to stiffen the screening of the P.I. immigrants for TB, the incidence of the disease could be markedly decreased.

Sincerely,
W.A. SHRADER, JR., M.D.

ALCOHOLISM DOESN'T CHANGE!
Alcoholism Literature DOES
Pamphlets available
TO HELP YOU HELP FAMILIES
Hawaii Committee on Alcoholism
575 Cooke Street
524-1144



Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

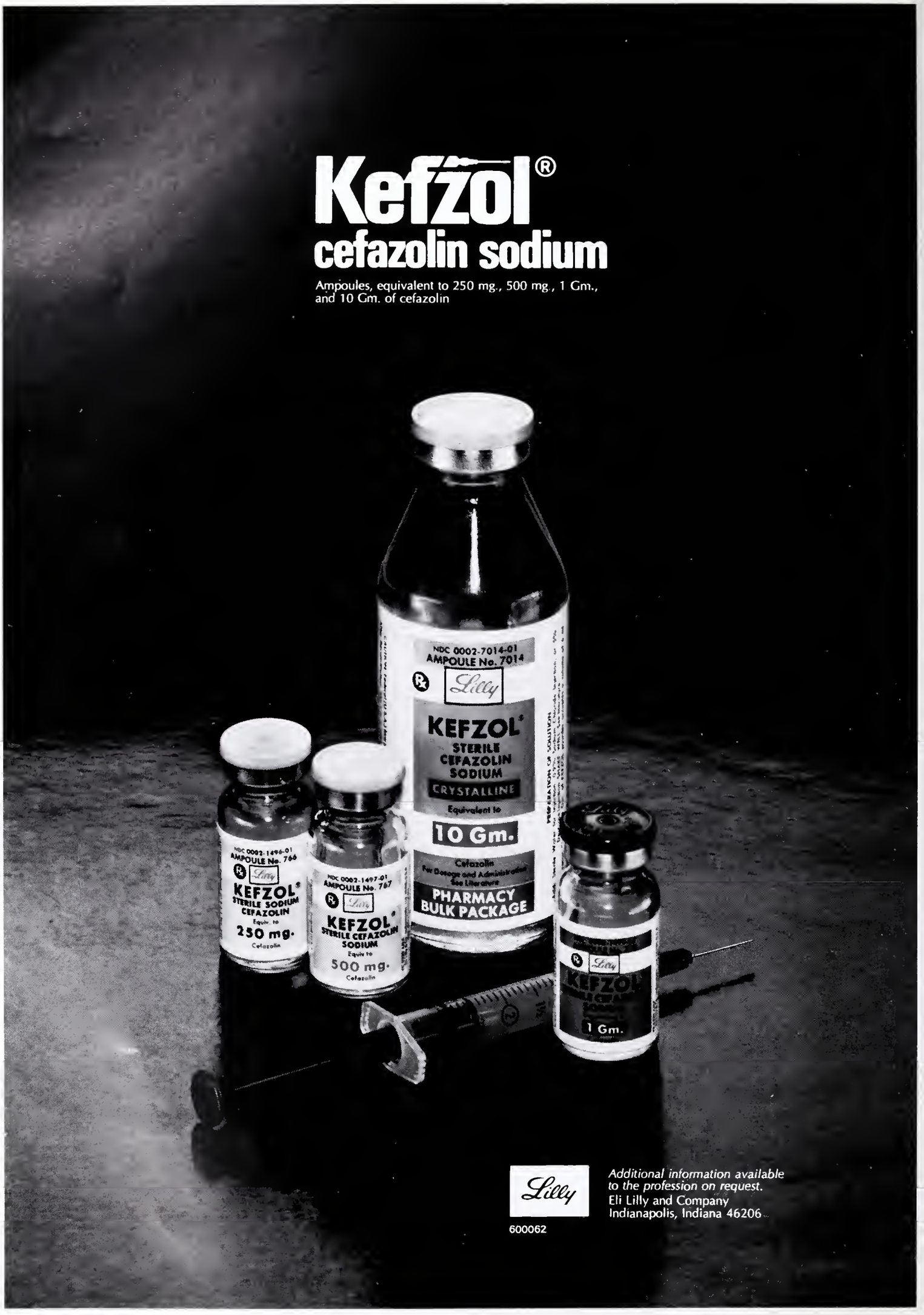
11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

P·M·A
Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005


Kefzol®
cefazolin sodium
Ampoules, equivalent to 250 mg., 500 mg., 1 Gm.,
and 10 Gm. of cefazolin
NDC 0002-7014-01
AMPOULE No. 7014
Lilly
KEFZOL®
STERILE
CEFAZOLIN
SODIUM
CRYSTALLINE
Equivalent to
10 Gm.
Cefazolin
PHARMACY
BULK PACKAGE
NDC 0002-1496-01
AMPOULE No. 766
KEFZOL®
STERILE SODIUM
CEFAZOLIN
Equiv. to
250 mg.
Cefazolin
NDC 0002-1497-01
AMPOULE No. 767
KEFZOL®
STERILE CEFAZOLIN
SODIUM
Equiv to
500 mg.
Cefazolin
1 Gm.
Lilly
Additional information available
to the profession on request.
Eli Lilly and Company
Indianapolis, Indiana 46206
600062

Distribution of HL-A Antigens in Korean Population

JIN POK KIM*, M.D., JOON H. HONG*, M.D., and
YOUNG K. PAIK†, M.D., *Honolulu*

● *Since the Human Leukocyte Locus-A (HL-A) system was defined as the major histocompatibility locus in man, leukocyte tyhping has made several important contributions in human biology and medicine.*

It has been demonstrated that there is a definite relationship between HL-A system and outcomes of organ transplantation.[1]

Based on the comparative statistical analysis of the distribution of HL-A antigens in normal populations and those with various diseases, the HL-A system was also shown to be intimately involved with disease susceptibility.[2]

Significant variations in the frequencies of HL-A antigens among different ethnic groups have been amply confirmed.[3-46] Because of its genetically complex polymorphism, the HL-A system is considered an important parameter in the study of the evolution of human populations.[13]

This study was conducted to determine the incidence of HL-A antigens in normal Korean populations.

Materials

A total of 196 Korean unrelated individuals were included in this study. The subjects were normal, healthy persons, consisting mainly of blood donors, staff members of hospitals and outpatient clinics visitors for health certificates, of either sex. They were mostly inhabitants of Seoul city and neighboring districts.

Methods

HL-A antigens were detected by microdroplet lymphocyte cytotoxicity test. HL-A antisera were supplied by the NIH serum bank. A total of 42 different antisera covering 16 different antigens were used.

All antisera were dispensed into 60-well Falcon microdroplet testing trays. To each well, five lambda of mineral oil was added using a Hamilton multiple dispenser and then one lambda of antiserum to each respective well. These preloaded trays were stored in 70°C freezer until use.

Isolation of lymphocytes were done according to Boyum's method with a slight modification[1,17-19] and usually completed within 6 hours after bleeding. Lymphocytes were isolated from heparinized whole blood by centrifugation over density gradient solution.

The lymphocytotoxicity was performed using a two-stage procedure according to the modified method of Terasaki and McClelland.[18,20]

Using the ordinary microscope with 10 x objective, small and refractile cells were considered to be intact lymphocytes whereas larger cells stained with trypan blue were considered as positive reaction.

Calculations

Gene frequencies (GF) were estimated from the phenotype distributions (PF) in unrelated individuals using the following formula, according to the Hardy-Weinberg law, as in other studies.[4,8,16]

$$GF = 1 - (1-PF)^{1/2}$$

Results

A total of 196 unrelated Koreans were tested for 16 HL-A specificities, 6 in the first sublocus and 10 in the second. Table 1 demonstrates a rather even distribution of antigens throughout the first and second subloci. HL-A2 (41.3%) and HL-A10 (27.1%) from the first sublocus and HL-A13 (41.3%) and HL-A12 (29.7%) from the second were the most frequently found antigens.

*Department of Surgery, College of Medicine, Seoul National University.

†Department of Pathology, St. Francis Hospital-University of Hawaii, School of Medicine.

Address reprints to: Young K. Paik, M.D., Department of Pathology, St. Francis Hospital-University of Hawaii, School of Medicine, 2230 LIliha Street, Honolulu, Hawaii 96817.

This study is partly supported by Regional Medical Program of Hawaii, Project #47.

Accepted for publication May 1, 1975.

TABLE 1.—*Incidence of HL-A Antigens in Koreans*

SUBLOCI	ANTIGENS	NO. OF POSITIVE	% (OF 155)
First	HL-A1	27	17.4
	HL-A2	64	41.3
	HL-A3	38	24.5
	HL-A9	29	18.7
	HL-A10	42	27.1
	HL-A11	16	10.3
Second	HL-A5	28	18.0
	HL-A7	36	23.2
	HL-A8	18	11.6
	HL-A12	46	29.7
	HL-A13	64	41.3
	Hl-A14	2	1.3
	HL-A27	1	0.6
	W5	25	16.1
	W10	20	12.9

The frequency of HL-A1 (17.4%) is considered significantly high.

Table 2 shows the gene frequencies of the HL-A antigens in the present study. This was calculated from phenotype data as described. In this group of Koreans, about 24% of antigens from the first sublocus and 15% of antigens from the second could not be defined and remained blank when tested against available sera at the time of this study. Comparative frequencies of HL-A antigen in various races are tabulated in Table 3.

TABLE 2.—*Gene Frequencies of the HL-A Antigens*

SUBLOCI	GENE	FREQUENCY
First	HL-A1	0.091
	HL-A2	0.234
	HL-A3	0.131
	HL-A9	0.098
	HL-A10	0.146
	HL-A11	0.059
	Total	0.759
Second	HL-A5	0.095
	HL-A7	0.124
	HL-A8	0.060
	HL-A12	0.161
	HL-A13	0.234
	HL-A14	0.006
	W27	0.003
	W5	0.084
	W10	0.066
	Total	0.833

Discussion

Reviewing the result of the present study, detection rate of antigens from each individual was relatively low, compared to other studies performed in other population groups[4,8] and there are as yet many antigens that are not detected with available antisera at this time, as can be seen from low gene frequencies.

In the Caucasian and Negro population,[4] about 98% and 88%, respectively of the genes for the first sublocus of the antigens and 89 and 79%, respectively, of those for the second are known by current population data.

Initial study of the Bantu tribe,[11] in South Africa, showed that nearly 35% of the people have no detectable antigens at the first sublocus, but it was later found that almost all of the antigens the Bantu possesses can be defined by the sera of the Bantu women.[10] Accordingly, it can be said that the Bantu have antigens that are unknown or rare in Europeans, and the antibodies against such antigens are present in the Bantu women.

Therefore, it would seem logical to test HL-A antigens of Koreans, using Korean women to define the blank antigens found in this study.

Recent studies show significant variations in the frequencies of HL-A antigens in different racial groups. In a large and heterogeneous sample of whites, Albert el al[4] found a high incidence of HL-A1 (26.1%).

Ting et al[15] studied Chinese, Malayans, and Indians in Singapore and found that, compared

TABLE 3.—*Comparison of Frequencies of HL-A Antigens In Various Races*

Population	Caucasians	Danes	Negro	Indian	Mexican	Eskimo	Oriental	Japanese	Korean
Investigator	Albert	Svejgaard	Albert	Hammond	Gorodezky	Dossetor	Albert	Yokohama	Hong, Kim, Paik
% (No. Tested)	(1028)	(457)	(280)	(147)	(200)	(?)	(156)	(93)	(155)
HL-A1	26.1	29.2	6.8	27	29.0	0	0	1.0	17.4
HL-A2	50.0	57.6	36.0	31	68.0	50.6	44	41.9	41.3
HL-A3	24.8	27.2	14.6	15	44.5	0.3	2	6.5	24.5
HL-A9	21.8	28.0	29.0	16	23.5	87.7	61	59.1	18.7
HL-A10	11.6	—	10.4	23	—	0	15	19.4	27.0
HL-A11	12.9	36.4	5.0	25	—	—	17	—	10.3
W19	8.1	—	3.5	10	—	—	—	—	—
W28	—	62.5	—	12	—	—	—	—	—
HL-A5	11.4	11.0	11.7	37	35.5	27.4	33	31.2	18.0
HL-A7	23.4	31.5	16.7	13	16.0	19.3	6	18.3	23.2
HL-A8	18.0	18.6	6.4	5	24.0	0	0	4.3	11.6
HL-A12	27.1	28.7	20.3	10	—	0	15	15.1	29.7
HL-A13	3.8	5.8	0.3	7	—	0	—	11.8	41.3
W5	14.6	24.1	28.6	34	—	10.7	21	—	10.7
W10	12.5	16.8	7.9	34	—	80.1	34	—	12.9
W15	10.3	—	1.4	17	—	—	16	—	—
W18	9.2	—	8.9	—	—	—	15	—	—
W27	9.1	7.8	3.9	1	—	6.3	6	—	—

to the Europeans, there is a market variation in HL-A distribution. In this Chinese population, there were a low incidence of HL-A1,10,7 and 8 and virtually no HL-A3. These results support the findings of Singal et al,[20] who found HL-A1 and HL-A8 to be absent in small Oriental population in Los Angeles, and Albert et al,[3] who also found a low incidence of HL-A1 as well as HL-A3,7 and 8 in 156 samples of various Oriental races. In Japanese, there are certain discrepancies between studies depending upon investigators. Yokoyama[16] reported the incidence of HL-A1,3 and 8 to be low (1.1,6.5, and 4.3%, respectively) in the Japanese population in Hawaii, but Ishibashi et al[12] showed a significantly different incidence of these antigens (11,29, and 7%, respectively) in a national survey in Japan.

From the present study of Korean populations in Korea, it can be stated that the incidence of HL-A antigens was rather evenly distributed and that HL-A1,2,8 and 13 behave as the most frequent antigens found in Koreans.

Ting et al,[15] Bodmer et al,[21] and Yokoyama[16] suggested the HL-A1 as a "Caucasian (European) antigen" on the ground of an absence of HL-A1 in Orientals, Babinga Pygmies and Japanese. However, in Koreans, the frequency of HL-A1 is relatively high (17.4%) and is midway between the frequencies of European and non-European populations. HL-A13, one of the most common antigens found in Koreans, has a low frequency in other populations, [3,4,8,14,16] Another significant difference can be noted in HL-A9 (18%) in Koreans, which seems to show a high frequency among Eskimos (87.7%) and other orientals (61%).

Summary and Conclusion

1. The HL-A antigens are rather evenly scattered in its distribution throughout the first and second subloci.

2. The most frequent antigens are HL-A2,13,12 and 10 in decreasing order of frequency. HL-A9 occurs rather infrequently compared to other Oriental populations and HL-A,1 which has been recognized to be rare from Orientals, occurs in about 17.4% of the population surveyed.

3. There is a large proportion of blank alleles, 25 and 15%, respectively, from the first and second subloci, which seems to be related to the limited number of antisera used.

REFERENCES

1. van Rood JJ, van Leeuwen A, Bruning JW, et al: The importance of leukocyte antigens in renal transplantation. Advance in transplantation proc. First Int. Cong. Paris. Munksgaard, Copenhagen, 1967.
2. Dausset Jean: Correlation between histocompatibility antigens and susceptibility to illness. Progress in Clinical Immunology, Grune & Straton, Vol. I, p183, 1972.
3. Albert ED, Mickey MR, McNicholas AC, et al: Seven new HL-A specificities and their distribution in three races. Histocompatibility Testing 1970, Musksgaard, Copenhagen, p221, 1970.
4. Albert ED, Mickey MR, Terasaki PI: Genetics of four new HL-A specificities in the Caucasian and Negro population. Transplantation Proceedings, 3;95, 1971.
5. Albert MD, Mickey MR, Ting A, et al: Deduction of 2140 HL-A haplotypes and segregation analysis in 535 families. Transplantation proceedings, 5;215, 1973.
6. Brain P, Hammond, M.: Leukocyte antigens in three race groups. *Med Proc*, 14;589, 1968.
7. Dausset J, Colombani J, Legrand L, et al: Genetics of the HL-A system. Deduction of 480 haplotypes. Histocompatibility Testing, 1970, Munksgaard, Copenhagen, p53, 1970.
8. Dossetor JB, McConnachie PR, Stiller CR, et al: The major histocompatibility complex in Eskimos. Transplantation proceedings, 5;209, 1973.
9. Gorodeszky C, Escobar-Gutierrez A, Salazar-Mallen M: Distribution of some of the HL-A system lymphocyte antigens in Mexicans. II. Mestizo and Mexican Indian population. Vox Sang., 23; 439; 1972.
10. Hammond MC, Appadoo D, Brain P: HL-A antigens antibodies in South African Bantu. *Transplantation*, 14;159, 1972.
11. Hammond MC, Brain P: Reaction of HL-H antisera in three populations. Vox. Sang., 20;492, 1971.
12. Ishibashi Y, Matsukuma Y, Tsuji K, et al: National survey of incidence of the HL-A antigens in Japanese (in Japan). *Transplantation J*, 6;86, 1971.
13. Rubinstein P, Costa R, Van Leeuwen A, et al: The Leukocyte antigens of Mapuche Indians. Histocompatibility Testing 1970, Munksgaard, Copenhagen, p251, 1970.
14. Svejgaard A, Thorsby E, Hauge M, et al: Genetics of the HL-A system, A population and family study. Vox Sang, 18;97, 1970.
15. Ting A, Wee GG, Simons Morris PJ: The distribution of HL-A leukocyte antigens in Singapore Chinese, Malays and Indians. Tissue antigens, 1-258, 1971.
16. Yokoyama W, Yokoyama M: Incidence of HL-A antigens in the Japanese population of Hawaii. Japan. *J Exp Med*, 43;81, 1973.
17. Boyum A: Separation of leukocytes from blood and bone marrow. Scand. *J Clin Lab Invest*, 21 suppl. 97,1; 1968.
18. Terasaki PI, McClelland JD, Par MS, et al: Microdroplet lymphocyte cytotoxicity test. Manual of tissue typing technique, NIH, Bethesda, Maryland, p54, 1973.
19. Thorsby E, Anne Bratlie: A rapid method for preparation of pure lymphocyte suspensions. Histocompatibility Testing 1970, Munksgaard, Copenhagen, p665, 1970.
20. Terasaki PI, McClelland JD: Microdroplet assay of human serum cytotoxins, Nature, 204;998, 1964.
21. Bodmer JG, Bodmer WF: Studies on African Pygmies. IV. A Comparative study of the HL-A polymorphism in the Babinga Pygmies and other African and Caucasion populations. *Amer J Hum Genet* 22;396, 1970.



H. Tom Thorson

Malpractice insurance hearings have started. The first hearing before the combined committees, Judiciary in the Senate and Consumer Protection and Commerce in the House was held Monday evening, March 2. Testifying for various aspects of the bill were Drs. Pavel, Chun-Hoon, Larry Gordon, Winfred Lee, Leonard Howard. Opposing many features of the bill, particularly the limitation on general damages and contingency fees were the trial lawyers. General support from all parties was expressed for the idea of the patients compensation fund.

More hearings are scheduled prior to the decision making but at the moment the proposal is moving along. It would appear that the other bills submitted will be reviewed and desirable features incorporated into the administration measure—HB 2700 and SB 2332.

Thousands of the folders requesting patient support for the changes in the laws relating to malpractice have been mailed out—let's hope for a large volume response.

Testimony has been presented on a variety of bills, among them HB 2037, relating to medicaid payments. This important measure stems from the inability to work out with the DSS regulatory arrangements to provide for equitable payments. Apparently the only way to go is through the legislature. The prospects look good for passage of the measure requiring the DSS to make payments for service at the maximum level allowed by Federal regs.

School health mental health, immigrant health problems, drug substitution, sterilization, the criminally insane, etc., have all received attention. The definition of death and the death with dignity bill have been reviewed. HMA has opposed legislation permitting the overt act of inducing death.

Max Parrot, President of the AMA challenged the Illinois officials to release to the medical society the name of physicians charged with fradulent claims so that the society could administer proper discipline. so far the state of Illinois has refused.

Successful Seminar on office management was held at the Mabel Smyth Building on March 2. George Conomikes, management consultant presented management techniques to forty physicians. Mr. Conomikes spoke at the meeting of the Honolulu County Medical Society the same evening.

President Dang made his visit to the Honolulu County Medical Society on March 2, and presented the "Dang Plan." He visited Maui County on February 20, and will visit Kauai County on March 12.

Change In Medical Education has come about quietly.

* 58% of all new MD's are entering primary care residencies
* 69% increase of first year medical students in past ten years
* Number of medical schools gone up by 27
* Record enrollment of women—up 360% in four years.

National Endowment for the Humanities will hold four seminars-

1. June 1 to 30, at University of Pennsylvania in Philadelphia. Topics—health and illness, process of professional development, modern medical research, bio-ethical issues. Contact Renee C. Fox, Dept. of Sociology, 128 McNeil Bldg., U of Pennsylvania, Philadelphia, Pa. 19174.
2. June 28-July 23, at Stanford University in California, covering the role of the practitioner in the community, doctor-patient relationship, decision making ethos of a hospital, and the claims of society. Contact William F. May, Chrmn, Dept of Religious Studies, Sycamore Hall 230, Indiana University, Bloomington, Indiana 47401.
3. August 9-September 3, Ohio State University, Columbus, Ohio. The subject matter will cover historical forces that shape the medical profession in the context of western culture. Contact John C. Burnham, Dept of History, Ohio State University, 230 West 17th Avenue, Columbus, Ohio 43210.
4. September 13-October 8, University of Texas Medical Branch in Galveston, Texas. This will cover patient's rights, the right to health care, as related to basic philosophical and ethical issues. Contact H. Tristram Englehardt, Jr., Institute for the Medical Humanities, Univer-

sity of Texas Medical Branch, Galveston, Texas 77550.

Attendance at all of the above is limited to not more than fifteen. Each person accepted will receive a stipend of $1200, plus travel expense of not more than $300. Applications can be obtained as listed above. The filing dates for the first two will be April 15, and for the second two, May 13.

The purpose of the seminars is to bring humanistic knowledge and understanding to bear on problems in the practice of medicine.

We Were Right: The Beverly Hills-based Doctors Guild, Inc. and its operator Carl Fidler, who offered to arrange medical malpractice insurance for doctors for a $100 fee, were accused of unauthorized transaction of insurance. Dep. Atty. Gen. Klimmek, acting on behalf of state Insurance Commissioner Wesley Kinder, filed a Superior Court civil suit to stop solicitation of doctors by Fidler and group.



We Are All Too Busy.

For a physician to take time away from patient care, his motives and efforts must be defensible, for they are often subject to criticism.

A physician's training is so long, so complex, and so specialized, that for him NOT to apply his knowledge and experience, once he gets into direct patient care, is considered wasteful indeed.

We can write off, of course, in this treatise, those MDs who are involved in teaching, or who work in health departments, or who are under salary or contracts.

Those of us who are involved in direct patient care usually have little time left for ought else. We might list such extra-curricular activities and examine them in order of importance.

Would you place care-of-self as number one? Some do: Those who MUST have their sleep. Or their exercise (from golf to marathon-running). Or their relaxation. Others do not: They continue to function for long hours, though dead-tired. Such are the trauma surgeons, some cardiologists, and particularly those who deliver babies in large numbers. Maybe they are so tired that they function less well and perhaps commit more errors. Not so! We tend to believe that fatigue is more of a psychological state than a physical one, and that the human brain's reserves are almost limitless.

Next, what about CME? To most physicians, the term itself is an insult to the profession, especially when pontificated by do-gooders. Every patient, every case, every medical experience is Continuing Medical Education *per se*. Physicians, above all others, must and do forever learn as they "practice" their profession. So, why do these do-gooders that plague us make such a big thing out of forcing us to attend a course or seminar—which are very easy to sleep through when slides are projected on a screen—in order to get "credit"? Nevertheless, time spent by us in CME in whatever form, is accepted by our patients as deriving to THEIR benefit. Therefore, we read and study and go to medical meetings. When we tell them that we are going to such a meeting in Chicago, or New York, or London, or even Kapingamarangi, they are impressed—perhaps more by the tone of the doctor's voice than by the alleged substance of the excursion.

Next, we involve ourselves as physicians in medical administrative matters. The steps begin with medical staff work in hospital, and proceed to the many steps up the ladder of organized medicine. Our patients don't know too much about this, behind the scenes, participation. As with CME, most of the time we are available through the Physicians' Exchange. The higher up the ladder we go, the more our patients sense their doctor is going a little far afield. They perhaps rationalize by thinking his time is being subtracted from his game of golf (not likely!), or from family activities (quite likely!), or that he gets to bed later (especially after an HMA Council meeting!). They become more than somewhat resentful if he becomes even less available to them in time of need, when he becomes more part-time in the office because of these extra-curricular activities. The example of the ultimate in this is the physician who takes himself clear out of direct patient care by accepting election to high office as a full-time job either within the profession, or without, such as becoming a legislator or governor.

One can argue strongly on both sides of the latter issue. A: "What a waste of highly technical expertise!" B: "Well, someone that knowledgeable in his field is absolutely essential in the political arena!"

There is more to come.

J.I.F.R.



New Members



Sukchai Sattapankiri
Kona Medical Associates
Kealakekua, Hawaii 96750
INTERNAL MEDICINE



Joel K. Sims, M.D.
1301 Punchbowl Street
Honolulu, Hawaii 96813
EMERGENCY MEDICINE



Karl K. Hanaoka, M. D.
1507 South King Street
Honolulu, Hawaii 96814
RADIOLOGY



Richard A. Williams, M.D.
200 Vineyard Street
Honolulu, Hawaii 96817
OBGYN



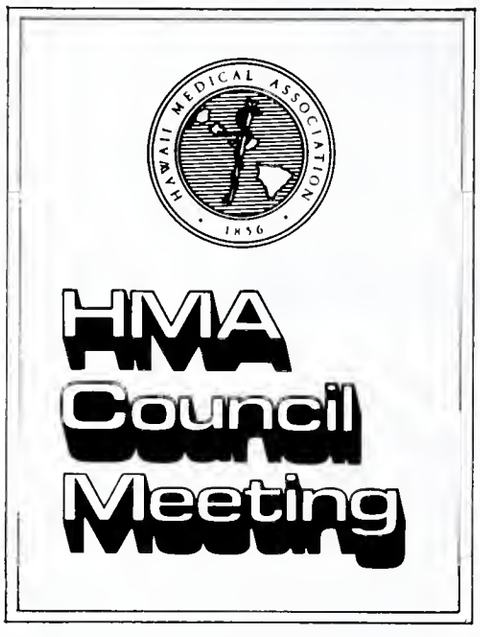
Ung Lee
101 Hualalai Street
Hilo, Hawaii 96720
OBSTETRICS & GYNECOLOGY



John Newman
1292 Waianuenue Avenue
Hilo, Hawaii 96720
FAMILY PRACTICE



Donald C. Nickon, M.D.
1301 Punchbowl Street
Honolulu, Hawaii 96813
RADIOLOGY



August 29, 1975, 5:30 p.m.
Mabel Smyth Lanai

CALL TO ORDER

The meeting was called to order by Dr. Dang since Dr. Lee was delayed. Also present were Drs. Grover Batten, Herbert Chinn, George Goto, J.I.F. Reppun, Arnold Siemsen, Ann Catts, Peter Kim, Sakae Uehara, Rowlin Lichter, Verne Adams, Albert Chun-Hoon, Marion Hanlon, Douglas Bell II, William Iaconetti and Mrs. Alice Tucker.

MINUTES

A member recommended addition of "non-voting" after *ex-officio* on page two of the August 7 minutes on the third line

down. The minutes of the August 7 meeting were approved with recommended revision.

TREASURER

The financial statement for July 1975 was reviewed.

ACTION: It was voted to accept the financial report for July 1975 subject to audit.

COMMITTEES AND COMMISSIONS

A. PI 93-641: A Hawaii Public Health Association workshop will be held on September 16 at the Ala Moana Hotel on PL 93-641. Dr. Dang reported that funds are available through DHEW if an agency would like to conduct a 3-year study as to the feasibility of developing a Health Service Agency.

ACTION: It was voted to recommend that HMA apply for a grant to pursue a study on the feasibility of setting up a Health Service Agency (HSA).

B. Tel-Med: Dr. Lichter presented the proposed budget for a local Tel-Med program along with recommendations as to prospective sponsors of the system. Dr. Lichter was asked to present a report as to any sponsorship commitments for Tel-Med at the next Council Meeting.

ACTION: It was voted to accept the proposed budget for Tel-Med.

C. Subcommittee on Medical Practice Act: At the first meeting of the subcommittee the Hawaii Medical Practice Act was reviewed with emphasis on those sections needing revision. The subcommittee's recommendations will be presented at the next Council meeting.

D. Joint Underwriting Committee: The Joint Underwriting Committee, consisting of Dr. Chun-Hoon, Mr. Thorson and eight other members, that has been set up under the JUA law has had its first meeting. Dr. Chun-Hoon noted that if there is no insurance coverage available, this law will go into effect and all physicians must get their coverage through the JUA regardless of other coverage unless they are self-insured. At the first meeting, the law itself was reviewed, the policies were being drafted, and it was discovered that many items were not defined such as what is a "physician" and what is a "hospital" under this law. Mr. Thorson reported that the policies under JUA will be on an occurrence basis, that peer review committees will be used in the evaluation of underwriting problems, and that coverage will be limited to physicians licensed under HRS Chapter 453(M.D.'s) and Chapter 460(D.O.'s). Hospitals are defined as acute care facilities, SNFs and INFs licensed by the DOH.

E. Mutual Insurance Company: The formation of a corporation, Hawaii Health Research, Inc., for the proposed mutual insurance company is currently underway with Mr. Walter Chuck as the appointed attorney for the venture. Mr Chuck is in the process of revising the management contract submitted by Frank B. Hall Co. A feasibility study on local claims experience will be conducted if the Council approves the new management contract.

F. Legislation: Dr. Goto reported that several persons are being considered for the position of Legislative Counsel, however, no one has been given a firm commitment. Since the Legislative Committee has not met since the last Council meeting, the Council again requested that they submit their recommendation regarding Legislative Counsel including the budget requirements by the next Council meeting.

G. Pharmacy Committee: The Council reviewed a recommendation submitted by the Pharmacy Committee regarding an amendment to Public Health Regulations on dispensing of controlled substances in emergency rooms.

ACTION: It was voted to submit the amendment to legal counsel for review and requested that a member of the Pharmacy Committee clarify the proposed amendment.

H. Woman's Auxiliary: Mrs. Tucker reminded board members that AMA-ERF donations can be channeled to the medical school of choice if specified on the check. When budgeting for the coming year, Council members were asked to raise the Woman's Auxiliary allotment as of July 1, 1976 by $3.00 per person since National Auxiliary dues will increase proportionately as of that date.

I. Public Health: Dr. Sia submitted a written report outlining the activities of the committees under the Public Health Commission since the last Council meeting. The recommendation of the Communicable Disease Committee regarding TB testing was referred back to committee for clarification.

ACTION: It was voted to approve the Communicable Disease Committee recommendation regarding pediculosis in Hawaii's schools.

J. Health Services and Care: Dr. Bell reported that the Health Manpower committee has been studying the role of Physician Assistants, however, they have not yet formulated any recommendations for the Council.

K. Medical Services: The Fee Survey Committee has asked specialty societies and the Academy of General Practitioners to compare their respective sections from the 1974 California RVS and the 1970 Hawaii RVS for recommended changes or additions to be included in a 1976 Hawaii RVS should the House of Delegates approve such a publication.

Due to complaints from members regarding different factors for participating and non-participating physicians in HMSA, the Fee Survey committee would like to investigate the alleged unfair discrimination to find out if such complaints have merit.

ACTION: It was voted to have the Fee Survey Committee continue to pursue an investigation into the possibility of inequitable rates for participating and non-participating physicians in HMSA.

L. Site Committee: The Site Committee met and formulated five recommendations with regards to the future "home" of HMA-HCMS. The merits and de-merits of each recommendation will be presented at a future Council meeting.

M. Commendation: The Council voted to commend Mr. H. Tom Thorson for his recent Letter to the Editor regarding HMA involvement in the EMS program.

N. EMS: Due to the increasing costs of maintaining the EMS program the Project Director has requested support for a repeal of the Free Ambulance Act since many federal reimbursement dollars are lost each year through such a free service. Council members discussed the various aspects of the ambulance system in Hawaii presently.

ACTION: It was voted to recommend repeal of the Free Ambulance Act.

O. Cancer Commission: The Tumor Registry recently published a study on the patterns of cancer between 1960-1964 and 1968-1973. They are anticipating participation in a study on melanomas with other West coast registries.

P. PacPSRO: Dr. Lee reported that the meeting with DHEW officials in San Francisco proved to be discouraging since officials were not able to answer many of the questions raised by PacPSRO representatives, especially with reference to PacPSRO's data plan, since they had not reviewed the draft proposal for conditional designation.

Q. HPRO: Dr. Lee briefly discussed the proposed Hawaii Professional Review Organization which would function as the review entity for non-federal programs. Dr. Henry Oyama will head a committee to look into the feasibility of forming such an organization.

OLD BUSINESS

A. HMA/HAH Data Collection Hui: The Hawaii Medical Association and the Hospital Association of Hawaii are considering setting up a data collection hui, perhaps under the

Hawaii Health Research, Inc., to bid for the anticipated data processing duties under PacPSRO.

ACTION: It was voted that HMA further explore the possibility of forming a HMA/HAH data collection hui.

B. Presidential Assistant: Dr. Lee discussed the role of the President's Assistant with regard to job responsibilities and term of office.

ACTION: It was voted to approve Dr. Grover Batten as Presidential Assistant for the next 3 months.

C. Medicare Brochure: Dr. Reppun reported that the ad hoc committee appointed to prepare a leaflet on Medicare has not met as yet. The committee was asked to have their budget requirements ready by the next Council meeting.

ADJOURNMENT

The meeting adjourned at 9:30 p.m.

R. VARIAN SLOAN, M.D.
Secretary

Thursday, November 20, 1975, 5:00 P.M. Mabel Smyth Lanai

CALL TO ORDER

The meeting was called to order by President William W.L. Dang. Present were Drs. Winfred Y. Lee, Calvin C.J. Sia, R. Varian Sloan, Grover H. Batten, George H. Mills, Herbert Y.H. Chinn, Ann B. Catts, Albert Chun-Hoon, George Goto, Rowlin Lichter, J.I.F. Reppun, Sakae Uehara, Verne Adams, Peter Kim, Marion Hanlon, plus Drs. William Iaconetti and Roy Kuboyama and Mr. V. Thomas Rice-Legal Counsel.

MINUTES

The minutes of the September 26, 1975 meeting were approved as circulated.

REPORT OF THE SECRETARY

The report of the secretary was approved as circulated. It was noted that membership has increased to 1,018 members. It was suggested that the Public Affairs Committee consider a special honor for the 1,000 member to be inducted into the Association.

REPORT OF THE TREASURER

The financial statement for October 1975 was filed subject to audit.

ELECTIONS

Bureau of Research and Planning: Dr.William E.Iaconetti was asked to serve as chairman of the Bureau of Research and Planning for 1976. Members were elected for three-year terms as follows: Herbert Y.H. Chinn, John J. Lowrey, Winfred Y. Lee, Theodore T. Tomita and Tadao Nagashima (Hawaii).

Finance Committee: The Finance Committee for 1976 was elected as follows: Marcelino Avecilla, Elmer Johnson, Albert Chun-Hoon, John Edwards, Richard Omura and the treasurer from each county medical society.

Committees and Commissions: A listing of the commissioners and committee chairman for 1976 was approved as circulated.

MATERIAL FOR INFORMATION ONLY

CMA Dinner: An announcement for the December 2 dinner for the California Medical Association delegation to the AMA was circulated. Tickets are being sold through the HMA Office.

House of Delegates Actions: A summary of the actions of the HMA House of Delegates was circulated.

REPORTS OF THE COMMITTEES AND COMMISSIONS

A. *The "Dang Plan":* Mr. V. Thomas Rice, HMA Legal Counsel, presented a draft of the HMA's Capital Fund Advance Plan (The "Dang Plan") which might be circulated to the membership. After consultations with tax experts, accountants, and other advisors, to explore whether the establishment of such a fund would be feasible and whether contributions could be tax deductible, it was determined that the contributions to the fund cannot be made tax deductible to the contributing member. The matter of a tax-deductible contribution was debated at length as well as alternative plans such as the sale of stock in a corporation, a request to each contributor to pay the entire amount in full at the onset of the plan in order to create an immediate fund for the cash purchase of a building, etc. It was noted that the subject on the development of a capital fund was not a new subject and had been discussed at several Council meetings and at the House of Delegates and there was question whether the method for development of a fund was subject to debate.

ACTION:

A motion to postpone action for one month was defeated. A motion to accept the plan drafted by Mr. Rice as amended by the Council to include the specification that this plan applies to *active* members of the Association and the specifications for refund payments. A copy of the amended plan is on file in the HMA Offices.

B. *Site:* After the House of Delegates meeting, an option was signed and a deposit made on a building located on Ward Avenue. The conditions of the option are dependent upon Council approval. The option is open until December 1. The conditions and operation of the building were discussed in detail. An appraisal has been requested. The Council requested that a full appraisal of the site be performed to include a detailed breakdown of income and expense and costs of moving.

ACTION:

It was voted to postpone action until a full appraisal of the site could be completed. It was voted to request a two-week extension of the option and to schedule a special Council meeting for Friday, December 12.

C. *Medical Research Task Force:* Dr. Chinn reported his committee has investigated the feasibility of submitting a grant to become the Health Systems Agency of Hawaii under PL 93-641 and recommends: (1) That the HMA not submit a letter of intent to become the grantee for the Health Systems Agency at this time, and (2) Although we believe this legislation (PL 93-641) was hastily enacted and may create more problems in the health care delivery system than it will solve, it is recognized that the law is in effect and we plan to constructively react to the local non-profit agency or any other organization who may submit an application to become the HSA for Hawaii.

ACTION:

It was voted to adopt the recommendations of the Medical Research Task Force.

D. *Medical Malpractice:* Dr. Chun-Hoon reported a meeting of the Ad Hoc Committee on Medical Malpractice and Legislative Committee had been held with HMA's Legislative Counsel. The Counsel offered some criticisms of the proposal and the committees will work closely with him during the next few weeks to ascertain what modifications may be necessary. He also reported that the Committee on Medical Malpractice established by the Department of Regulatory Agencies plan to hold public hearings on the omnibus bill being drafted by that group on December 8-10. There was discussion regarding contacts with state legislators on the subject of medical malpractice and members of the Council were encouraged to

contact their legislators and discuss with them the policies mailed out to all HMA members.

Mr. Thorson reported that the Board of Directors of the Joint Underwriting Plan are presently considering a "claims-made" type policy which is contrary to the "claims-occurrence" policy preferred by the HMA. Mr. Thorson was directed to try very hard to insure that safeguards are built in to protect the policyholders regardless of which option is selected.

E. *Tel Med:* Dr. Lichter reported that HMA's request to the Chamber of Commerce for funding of the TelMed project was approved and that HMSA has agreed to provide the balance of the funding for the project. HMSA has asked for a three-year commitment for the project and after this period, either party has the option to continue or terminate the program. The HMA will provide professional medical direction and review all tapes for the program. The TelMed equipment will be brought to the AMA Convention where it will be installed for a trial period and then transferred to space in the Nurses and Physician's Exchange in the Mabel Smyth Building. The details of the contract with HMSA were reviewed.

ACTION:

It was voted to approve the HMSA sponsorship of the Tel-Med program with the agreement that HMA will review the tapes.

Dr. Lichter was asked to report back to the Council with the composition of the administrative committee for the program.

NEW BUSINESS

A. *Jail Study:* The AMA has called for the submission of grants to study medical care and health services in jails. They have been awarded funds for several pilot studies throughout the United States. The Department of Social Services of Hawaii has indicated they would be interested in participating in such a study and Dr. Benjamin Lambiotte has agreed to become the principal investigator for the project. The protocol has been drafted and must be submitted to the AMA by November 29, 1975.

ACTION:

It was voted to support the proposal.

B. *Chiropractic:* The HMA has been notified that chiropractors are striving to have chiropractic services included under various insurance plans.

ACTION:

It was voted to refer this matter to the Legislative Committee and ask that the committee continue HMA's previous position of opposition to chiropractic care.

C. *Assistant to the President:* Dr. Dang noted that Council had given permission to retain an Assistant to the President for a three-month period which ends November 30. He asked for permission to extend this time in view of the details with the new site and the implementation of the capital fund program.

ACTION:

It was voted to permit the President to retain an assistant as long as needed.

ADJOURNMENT

The meeting adjourned at 11:30 p.m.

R. Varian Sloan, M.D.
Secretary

Hawaii Academy of Family Physicians' Newsletter

J.I. Frederick Reppun, M.D.

DROPPED FROM MEMBERSHIP — James Phillips MD of Kamuela on the Big Island for failure to be recertified as of 31 Dec 1974 on the basis of insufficient credit hours. **James Silver MD** with the Military has resigned in order to go into Occupational Medicine.

FP WANTED — Family Medicine/North Shore Clinic is still looking for a general practitioner to join them. Call Harriet Wikum at 531-2524 or Jud McNamara MD if anyone is interested.

NEWS OF MEMBERS — Edwin Willett MD has joined Frank A. Ferren MD in Kailua-Kona. **Kats Izumi** on Maui has been elected to Life membership. **Lincoln Luke**, our president-elect, will be attending the State Officers Convention in Kansas City 24 & 25 April. Our president **Don Farrell** plans to attend the Family Practice Teaching Workshop on 29 March. **Fred Reppun** was the only Family Physician to attend a meeting called by Rep. Kate Stanley just after the opening of

HIGUCHI INSURANCE AGENCY, INC.

536-6070 or 531-5436

HONOLULU COUNTY MEDICAL SOCIETY'S
INSURANCE PROGRAM ADMINISTRATOR

TERM LIFE INSURANCE
DISABILITY INCOME INSURANCE
MAJOR HOSPITAL INSURANCE
DEFENDANTS REIMBURSEMENT INSURANCE

the legislature, to get the opinions of some 15 physicians who attended as regards DSSH, Medical Malpractice, etc. Fred later presented testimony at a hearing on DSSH fees to physicians, this being based on the results of the questionnaire on Conversion Factors. The data from only 35 responders (the rest of you guys sure didn't help!) is being sent to each HAFP member by mail. The questionnaire was mailed out early in January. Additional responses will be welcome. **Felix Lafferty** also plans to attend the SOC in Kansas City in April.

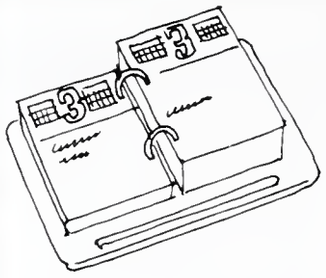
COMMITTEE ASSIGNMENTS — Pres. **Don Farrell,** with the concurrence of the Council, has made the following appointments of chairpersons for 1976: Legisl. & Public Affairs—**Liljestrand;** Medical Health—**Lafferty;** Health Care Service—**Cahill;** Education—**Dodge, Glover** and **Machigashira;** Cancer—**L. Luke** and **Fred Lam Jr.;** Membership—**Doris Jasinski;** Public Relations—**Lafferty;** Public Health—**Glover;** Constitution & Bylaws—**Pebley** and **Reppun.**

ABFP — Notice has been given that the examinations for certification will be given in 7 cities in the continental USA on 30, 31 October 1976. The examinations for the first *recertification* will be given in conjunction with the above on 29 October—a one half day written cognitive exam. The DEADLINE for application for these examinations is *15 June 1976.* Write N.J. PISACANO MD, Univ. of Kentucky Medical Center, Lexington, Ky 40506 for application.

CREDIT HOURS — Members need to be reminded once again to keep track of the sessions and seminars they attended during each three year term, and especially to *record at the time* the category—whether P or E. The AMA's Category 1 towards the Physician's Recognition Award is not automatically P as far as AAFP is concerned. Your Exec Sec helps you out by sending out every year a list of P-accredited courses. It is next to impossible to figure out your credit hours for you, as attendance is not usually recorded. YOU HAVE TO TALLY YOUR OWN! If you forget to record at the time, it should be easy for you to check off on the Exec. Sec's listing, and return to her, the items you remember attending. SAVE THE LISTS SHE SENDS YOU!



"It's a get-well card from all the nurses on the floor."



Continuing Medical Education

CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS: ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m.

Kaiser Hospital

(Contact CME Dept. for further information)

Kauikeolani Children's Hospital

1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program

Kapiolani Maternity Hospital

1. Grand Rounds, Wednesdays, 7:30-8:30 a.m.
2. Resident Conference, Tuesdays (except 1st), 1:00 p.m.
3. Ob-Gyn Department Meeting, 1st Tuesday, 1:00 p.m.
4. UH Seminars, Wednesdays, 3:30 p.m.
5. Perinatal Conference, Thursdays, 3:30 p.m.
6. Tumor Board, 1st & 3rd Fridays, 1:00 p.m.
7. Oncology Conference, 4th Friday, 1:00 p.m.
8. Visiting Professor Program

Kuakini Hospital

1. Hematology Rounds, Monday, 1:00-2:00 p.m.
2. Gastroenterology, Tuesday, 8:00-9:00 a.m.
3. Oncology Conference, Thursday, 8:00-9:00 a.m.

WILLIAMS MORTUARY

"CHAPEL OF THE CHIMES"

1076 S. Beretania St., Phone 537-2587 **Ample Parking Adjoining Mortuary**

OVER A CENTURY OF SERVICE

"Service measured not by gold but by the Golden Rule"

MEMBER

National Selected Morticians, National Funeral Directors Association,
Order of the Golden Rule, Hawaii Funeral Directors Association

4. Endocrine Conference, 2nd Wednesday each month, 1:00-2:00 p.m.
5. Medical Statistics, 3rd Tuesday each month, 1:00-2:00 p.m.
6. Renal Conference, Wednesdays, 1:00-2:00 p.m.
7. Kidney Biopsy Conference, Tuesdays, 1:00-2:00 p.m.
8. Visiting Professor Program
9. G.I. Rounds, Tuesdays 8:00 a.m.
10. Infectious Disease Conference, Thursdays 1:00 p.m.

St. Francis Hospital

1. Medical Grand Rounds, Tuesdays (4th & 5th), 1:00-2:00 p.m.
2. Surgical Grand Rounds, Fridays (except 4th), 7:30-8:30 a.m.
3. Tumor Conference, Mondays, 7:30-8:30 a.m.
4. Visiting Professor Program
5. Clinical Pathology Topics, Mondays, 10:00-11:00 a.m.
6. Microslide Conferences, Tuesdays, 8:30-9:30 a.m.
7. Bone Marrow Pathology, Tuesdays, 2:00-3:00 p.m.
8. Basic Science Review & Research Conference, Thursdays, 1st & 3rd, 8:00-9:00 a.m.
9. Psychiatric Case Conference, Tuesdays & Fridays, 8:00-9:00 a.m.
10. Psychiatry for the Non-Psychiatrist, Tuesdays, 10:00-11:00 a.m.
11. Psychiatry Teaching Rounds, Thursdays, 9:00-10:00 a.m.
12. Medical Psychiatric Joint Teaching Rounds, Fridays, 11:00-12:00 noon
13. Surgical Mortality & Morbidity Conference, last Friday, 7:30-8:30 a.m.
14. Saturday Teaching Rounds, Saturdays (except 4th), 7:30-8:30 a.m.

Straub Clinic & Hospital

1. Medical Grand Rounds, first Thursday, 7:00 a.m.
2. Surgical Mortality & Morbidity, 4th Thursday, 7:00 a.m.
3. Quarterly Professional Staff Meetings, (Jan., Apr., Aug., Nov.), 4th Monday, 7:30 p.m.

Wahiawa General Hospital

1. Noon Seminars, 2nd Friday & 4th Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:30 p. m. & 2nd Wednesday, 12:30 p.m. of each month in the Mabel Smyth Building. Contact HMA Office as dates are subject to change.

SPECIAL EVENTS 1976

April 7-9 Pediatric Gastroenterology, sponsored by Kauikeolani Children's Hospital; at Princess

THE NEW SHAPE OF ALOHA



Ka Waena Lapa'au

The Medical Center for the people of the Big Island

This new professional *medical arts office complex* in Hilo, is completed and located near Hilo Hospital. The Medical Center contains X-ray and lab facilities, a pharmacy and snack shop. Office space (loft) is now available for lease.

For a **Free Building Brochure**, Call or Write: Richard Smith, The Medical Center, 670 Ponahawai Street, Hilo, Hawaii 96720 Phone: 935-9808 or 961-3084.

Kaiulani Hotel; 15 hours credit; fee: $35.00. For further information, contact Dr. S. L. Hammar at 531-3511. Advanced registration is required.

April 14 — "The Establishment of Evaluation of CORE Competencies in Adult, Adolescent, and Child Psychiatry—A Study of the American Board of Psychiatry and Neurology" sponsored by the Hawaii Psychiatric Society, at 7:30 p.m. in the Mabel Smyth Bldg. For further information contact Mrs. Arien Grabbe (595-6371).

May 1-8 — Management of the Surgical Patient at Mauna Kea Beach Hotel, Kamuela; sponsored by Stanford University School of Medicine; 27 hours credit; for more information, write: Edward Rubeinstein, M.D., Associate Dean, Postgraduate Medical Education, M121, Stanford University Medical Center, Stanford, CA 94305.

June 20-25 — South Pacific Commission Cancer Seminar at the Pagoda Hotel, sponsored by the American Cancer Society. Contact: John R. Watson, M.D. or Kay VanSant at 531-1662.

The seminars on "Sexual Counseling: Office Management of Sexual Problems" sponsored by the ACOG and University of Hawaii will be held on the following dates: (20 hrs. credit)

March 22-26	November 22-26
April 19-23	December 20-24
October 18-22	

April 11-16 — Colposcopy—A Refresher Course, at Lahaina, Maui; 25 hours credit.

For further information, write to: American College of Obstetricians & Gynecologists, Department of Continuing Education, 1.E. Wacker Drive, Suite 2700, Chicago IL. 60601

Programs sponsored by the University of Southern California:

April 24-May 1 — Chest and G.1. Radiology, at Royal Lahaina Hotel, Maui.

April 24-May 1 — Pediatric Review, at Maui Surf, Maui.

April 26-May 1 — Diagnostic and Therapeutic Skills, at Mauna Kea Beach Hotel, Kamuela, HI.

April 26-May 1 — Emergency Medicine, at Kauai Surf, Kauai.

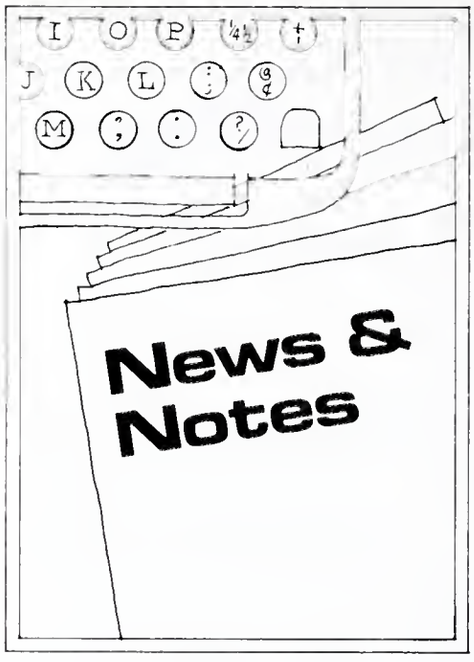
May 23-30 — Nephrology, at Maui Surf Hotel, Maui.

June 13-20 — Orthopedic Review, at Mauna Kea Beach Hotel, Kamuela.

For further information, contact: Phil R. Manning, M.D., Associate Dean, Postgraduate Division, USC School of Medicine, 2025 Zonal Ave., Los Angeles, CA 90033.

OUT OF STATE

For information on any out-of-state programs or courses, refer to August 11, 1975 Supplement to JAMA or call the HMA Office.



HENRY N. YOKOYAMA, M.D.

Life in These Parts

Item from *HMA Newsletter*, Jan. issue: "Dr. **Irwin J. Schatz,** chairman of the Dept. of Medicine of the John A. Burns School of Medicine, announces the start of *Ground Rounds* twice monthly for all community physicians and medical school faculty." (Tom Thorson says he has received many phone calls inquiring if the *Ground Rounds* would be convening at McDonald's . . .)

Cora and **Francis Au,** culminating a month of vigorous practice, did a 3 minute Cha-Cha demonstration at a recent gathering of the 9 chapter Hawaii Dance Association . . . We learned that **Tom Oshiro** has been taking lessons longer than most and is an accomplished dancer . . . At a recent 7 course dinner at Ming's Palace the Waialae golfers feted the victorious Mid Pac golfers. After only 4 courses, we were flabbergasted when **Ed Izawa** and **Hideo Oshiro** both excused themselves—rather sheepishly—to attend their weekly dancing lessons . . . Another dancing enthusiast **Masaru Koike** claims that the lessons have improved his golf game as well . . .

For years we have been an avid reader of **Bob Moser's** Materia Medica, a delightful, informative column appearing weekly in the *Maui News*. Recently Bob described a peculiar disease endemic on Maui and which he says does not appear in any of the medical textbooks. Bob says: "The disease afflicts mostly men between 16 and 50 (although last week I saw my first case in a young woman). It causes temporary loss of the natural instinct of self preservation. And, strangely enough, it occurs only while the victim is driving an automobile . . . The principle physical finding is apparent paralysis of the left arm—which evidently causes it to dangle helplessly outside the window of the moving vehicle. There appears to be no loss of power in the right arm since usually it is occupied furiously—steering, shifting gears, lighting cigarettes, and occasionally holding hands (with another passenger—usually female—who does not seem alarmed over the paralysis of her driving partner's other arm.) It does not seem related to paralysis of the legs, but I have suspected it is sometimes associated with spasm of the right foot—causing it to jam down on the gas pedal . . . The episodes are variable in duration—from a few minutes up to half an hour . . . And most astonishingly of all—the paralysis vanishes completely when the individual leaves the automobile . . . No one knows how to treat this curious illness . . ." (Which we should hereinafter call the 'Moser Syndrome' and be on the lookout for this syndrome in Honolulu)

On the 16th day of the "nurse" strike of 6 major hospitals, our favorite medical writer, Tomi Knaefler, wrote: "Surgeons without surgery are like mathematicians without numbers or knitters without yarn" . . . A Kaimuki surgeon interviewed said, "I'm reading a lot . . . One nice thing, I'm saving

on gas and I don't have to fight the traffic" . . . Another surgeon's wife, whose husband's workday starts at 6:30 a.m. and ends after the kids are in bed said, "It's a treat to find him home for dinner and even breakfast—would you believe it?" A St. Francis surgeon said "The strike is improving my golf . . ." A hospital official said, "At first, the surgeon's lounge looked like a tea party with all the surgeons sitting around talking, waiting, and appearing somewhat lost." (Perhaps an occasional strike is good for our souls . . .)

We are happy to report that The Hawaii Emergency Physicians Association (HEPA) has worked out satisfactory malpractice insurance rates with Argonaut and are continuing to service the Hilo and Wahiawa units . . . (Till June anyway)

A *Star-Bulletin* editorial of Feb. 18 gives us food for thought: "VITAL SERVICES"

The community owes a debt of gratitude to the doctors, non-striking nurses and volunteers who kept the hospitals in operation during the nurses' strike. Because of their dedication, tragedies that might have occurred did not. The use of the strike as a weapon in this essential area of service presents a difficult problem. In addition to nurses, doctors in several states have attempted to force action on their grievances—in the doctors' case, malpractice insurance rates—by withholding their services. Although the practice of medicine is not generally a governmental service in this country, it is obviously as important to the general welfare as any service performed by government. If a doctors' or nurses' strike lasted long enough, the situation would become intolerable. The fact that our nurses' strike ended before tragedy occurred should not be cause for complacency. It should serve as a warning of what could happen if we do not manage to avoid such confrontations in the future . . . "(We didn't know anyone really cared)

The 3rd Annual Honolulu Marathon was held in December with 706 runners completing the race as compared to 300 runners taking part in 1974. (1500 runners are expected in 1976) **Jack Scaff, Jr.,** chairman of the marathon, ran the 26 miles with a diamond engagement ring which he gave to Donna Tengan, ICU nurse when she completed the run . . . The Hunky Bunch also participated with 11-year old Daven Chun finishing 29th in a record 2 hours, 52 minutes, 9 seconds, and first in the Boys' 23 Under division. The only reported mishap came when June Chun collided with a car and sustained minor bruises. She was taken to the hospital via ambulance . . . The family award was given to the Hunky Bunch . . . Jack Scaff calls the marathon "reactivating Primeval Play"

We wondered about the following item in the *Maui News:* "The mass X-ray survey has served its purpose, and very well, but a *newer* method of detection—the tuberculin skin test—is now considered better, according to **Dr. Joseph Andrews** of the Maui unit of the American Lung Association."

At Kaiser Hospital, "Nancy Nurses" subbed for the 141 striking nurses. Nancy Nurses, we learned, are hospital physicians who served dual capacities as physicians and nurses. OB man **Paul McCallin** commented that it "makes you appreciate the nurses' job, which I used to take for granted." Pediatrician **Gloria Badua** enjoyed her nursing experience because it's "so practical," especially feeding time in the nursery. Fellow pediatrician **Alex Roth** admitted it had been quite a while since he had bathed a baby or done other grass roots type care of babies. "I guess I've been out of that since my children were babies, and that was a long time ago."

Professional Moves

The furious activity of the past six months has apparently subsided for we have found only two new announcements for February to date. Perhaps more are yet to appear later . . . Internist-hematologist **Fortunato Elizaga** opened at 1380 Liliha Street in Honolulu and psychiatrist **Jon Betwee** opened his office in Kihei, Maui. We did miss pediatrician **Martia Angleton's** announcement back in December. Martia associated with The Windward Medical Center.

There have been many appointments and resignations in the Health Department . . .one of which raisedquite a furor . . . Psychiatrist **Books Griffith** was relieved of his duties as head of the Kauai Mental Health Service. Books had taken over **Fred Weaver's** position (Fred also had to leave after a heated internal battle in the mental health service.) State Health Director George Yuen explained, "Unfortunately a situation has developed within the mental health center that his (Books') relation with the staff deteriorated . . . It's really a personality conflict . . . It's gotten to a point where morale was hurting and things were getting uncomfortable . . . There was no question about his professional competence . . . The best doctor in the world may not be the best administrator . . . " Adelaide Ward, chairman of the Kauai Mental Health Advisory Committee said that a two month investigation of the program was conducted before reaching a decision.

But it seems that other members of the same advisory committee were not in complete accord . . . Gary Fifield, director of Rehabiliation Unlimited, suggested, "It may not be too late to change the decision." Another committee member, James Jung Jr., public defender, proposed that a letter be sent to George asking him to enumerate the charges and to state the sources. The Rev. Paul Denise simply said, "The function of the advisory committee as stated by the bylaws is to learn the status of health care on Kauai." Phyllis Von Stronheim, director of Kauai YWCA said, "No one advised this committee which represents the community . . . It frightens me." In fact, the advisory committee members were quite indignant about the firing . . . and voted unanimously to inform George Yuen that Adelaide Ward, chairman, did not speak for the committee, and that it will ask for supporting data for George's decision and the sources of the information used in making the decision . . . The committee is concerned about the consistency of mental health care on the island since several psychiatrists in the past few years have faced nonrenewal of their contracts . . .

Other appointments and retirements were not contested. **Merle McPherson,** head of the maternal child health branch, succeeded **Angie Connor** as chief of the Child Health Services Division and **James Drorbaugh,** until recently regional representative of the China Medical Board of New York and former director of the maternal-infant health project at Childrens Hospital-Medical Center at Harvard University, replaced Merle as head of the maternal child health branch . . .

Opthalmologist **Dawson Mills** was appointed by George Yuen as state Emergency Medical Service system physician . . . Dawson has 27 years experience with the U.S. Navy as flight surgeon, general duty medical officer, opthalmologist and administrator and for the past seven years has been with the U.S. Department of Transportation, National Highway Traffic Safety Administration and initiated emergency medical service programs in every state . . .

George also appointed **Ernest Fogelberger** as the new clinical director in residence at the State Hospital and **David Everett Edwards** as admission unit chief of the State Hospital . . . And as we have mentioned previously, **Verne Waite,** former Honolulu proctologist and more recently with the Waimea Clinic, will take over as chief of the State Health Department's hospital and medical facilities branch, succeeding **David Holaday . . .**

Personal Glimpses

At a KCH Monday noon lecture, we met our humorous friend **Walter Young.** "Got any new jokes?" we asked . . . "Yeah! Let me show you the Portuguese coin trick . . . " Walt produced a coin from his pocket which he juggled behind his back. Then he slowly thrust both hands before us, one hand fisted and the other with fingers extended. "Which hand?" he asked innocently. During the luncheon, we noted on the printed schedule that the next lecture was "Revolutionary New Methods in Perinatology" by **Alistair Philip** (formerly with KCH, and now a visiting prof. from the University of Vermont.) We commented that perinatology wouldn't interest us since we didn't practice pediatrics and Walt quipped, "So you practice adultery?" Later, when the speaker mentioned something about paternity, Walt added, "Maternity is factual, but paternity is speculative . . ."

The scene: tennis locker room . . . **George Suzuki,** looking as sagacious as possible in his birthday suit, enunciated the following doctrine: "when six or more physicians are involved in the care of a patient, death is inevitable . . . " Henceforth to be known as Suzuki's law and perhaps an adaptation of the old adage, "Too many cooks spoil the soup."

The occasion: We were bemoaning the death of an elderly cardiac who caught the Victorian Flu, developed pneumonitis, acute pulmonary edema, liver failure, kidney failure, and finally a perforated viscus, all within a week. Besides our usual cardiologist, the house staff insisted on a respiratory specialist, a hematologist (for possible DIC), and a nephrologist (when renal failure started); and when the patient's arteries were spent, surgeon No. 1 to put in an intrabrachial catheter and lastly surgeon No. 2 who reluctantly explored for a ruptured viscus . . . (All for naught . . .)

Oops! We're slipping: A section of an autopsy report **Grant Stemmerman** had dictated was transcribed thus: "Primary hemochromatosis is believed to be a hereditary disorder due to a recessive gene with variable manifestations in heterozy*goats*."

We thought we had flattered **Sharon Bintliff** by calling her a "frustrated PE instructor" because she is a former Junior golf champ from Texas. She plays Class A tournament tennis, goes surfing in her spare time and has recently been paddling with a canoe club . . . At a KCH noon lecture, she scribbled us the following note: "My feelings were really hurt . . . If you'd said 'frustrated Olympic star' then it would have been OK!"

Bulletin

Our golfing pathologist **Tom Kobara** says the Hawaii Society of Pathologists will hold a 27-hole Florida scramble on Kauai, July 23 and 24 (Friday and Saturday). All physicians interested in either pathology or golf should place their reservations with either Tom or Art Salcedo, tournament co-chairmen. Tom promises ample prizes for everyone . . .

We learned that the following officers were elected by the Hawaii Society of Pathologists for 1976: President: **James Lumeng;** President-elect: **James Bennett;** Secretary-treasurer: **Stanley Hartroft;** CAP Delegate: **Herbert Uemura;** Alternate Delegate: **Young Paik;** ASCP Delegate: **Robert Flair.**

Miscellany

A drunk walked into a Baptist church on a cold winter night to get out of the falling snow . . . They were having a revival and he joined the singing . . . And when the offering plate was being passed around, he saw everyone put in money so he laid a $10 bill on top. The minister, surprised at the generous offering, asked the usher who the donor was . . . The usher replied, "I've never seen him before. He's singing like a Baptist, and gives like a Methodist, but he sure smells like an Episcopalian . . . " (Contributed by **Sharon Bintliff**)

Medical Facts (Gleaned from Playboy)

The Boston School of Medicine researchers have found evidence that Type B (serum) hepatitis can be trasmitted by sexual relations as well . . .

Sherman Silber, U of Cal urologist, reports a microsurgical technique for reversing vasectomies—using a 40-power microscope and special surgical instruments. Sherman says, "This technique promises to make vasectomy a more . . . acceptable means of birth control for males."

Elected, Appointed, Honored

Robert Worth is the chairman of the Department of Family Practice and Community health, recently established in the John A. Burns School of Medicine . . . **Jack Scaff,** marathon runner and organizer, was awarded the Scotty Schuman Award at the Honolulu Quarterback Club's annual banquet in Feb. . . . **J. Mark Sowers** was elected junior warden in the annual parish meeting of the Church of the Good Shepherd . . . **Fred Reppun** is the board chairman of the Kahaluu Neighborhood Board No. 29 . . . **Alice Broadhurst** was elected secretary of the Maui United Way for 1976 . . . **Richard You** is chief of the medical staff of the U.S. Olympic Hospitality Committee for the XXI Games July 17-Aug. 1 at Montreal, Canada . . . **George Mills,** who served as president of the Hawaiian Civic Club for 4 years, was honored at its 18th annual State Convention "for serving unselfishly and untiringly, giving so much of himself to the cause of helping the Hawaiian people follow the ideals which Prince Kuhio expressed in our constitution." **George Rhoads** and **Werner Schroffner** were recently made Fellows of the American College of Physicians . . .

Hors De Combat

Hilo Hospital physicians had a press conference and issued an appeal to the state legislators to find a solution to the spiraling costs of medical malpractice insurance . . . **Edward Ballerini,** chief of staff, said his premiums had jumped from $600 in 1969 to $6,500 last year. "Something in our society is going awry . . .The malpractice issue is a national dilemma . . ." **Manas Ghosh** felt that insurance companies should be required to reveal their incomes and expenses so that it can be determined whether the high premiums are warranted . . . **Paul Caldwell** said that he spends over $2,000 a year to go to the mainland to take medical courses because doctors are required to continue their education . . . The HEPA physicians malpractice agreement with Argonaut Insurance Co. is temporary and their contract expires on June 22.

Beware the Condor Trust . . . The "Condor Trust," with a nonexistent Vancouver, B.C. address, has been mailing local physicians fraudulent medical malpractice insurance proposals. Investigators say that all premiums collected have been forwarded to an individual in Los Angeles . . . Insurance commissioner Wayne Minami advises physicians to notify his office immediately upon receiving questionable proposals . . .

Kona had a recent rash of burglaries including four Kona hotels and a doctor's office . . . **Edwin Willett,** co-owner of the Kona Coast Medical Group, reported theft of money and a cassette tape recorder worth $550.

When attorney Stuart Cowan and his wife Jane decided to have their baby delivered in their Yacht Harbor Towers apartment, Jane's gynecologist balked. **Ralph Hale,** chairman of OB and Gyn and Kapiolani Hospital explained, "Every obstetrical delivery is potentially a life-threatening emergency for both the mother and child. When an emergency occurs, the patient needs and deserves the best care available if a tragedy is to be avoided . . . This level of care can only be given in a modern hospital delivery room . . . " Still, there has been a jump of home deliveries—from 56 in 1968 to 127 in 1974 . . . and many couples are turning to midwives. The Health Department is proposing even tougher rules for licensing nurse midwives (there are none in Hawaii at present). The proposals call for midwives to be a graduate registered nurse and a graduate of a school of nurse midwifery approved by the American College of Nurse Midwives. **Merle McPherson,** chief of maternal and child health branch of the State Health Department (which enforces the midwifery regulations), is sympathetic to the plight of women who feel hospital delivery is impersonal, but says, "the State discourages home births because risk is involved . . . Our concern is that women are able to have a satisfying childbirth experience in a safe environment with qualified personnel . . . At a Kauai hearing, family physician **Ronald Hattis** said the regulations have a flaw in that most physicians would not supervise home deliveries because "there's a lot of luck involved in these things and physicians would fear being sued for malpractice . . . " **Pat Aiu,** representing the American College of OB-Gyn, called existing provisions inadequate and supported the revised regulation.

More than a dozen major medical groups in the State warned legislators that unless Medicaid reimbursement rates are raised, their clinics will be forced to reject patients on welfare. **Roy Kuboyama** of the Kalihi Medical Center told the House Commmittee on Public Assistance and Human Services that the Medicaid reimbursement rate has failed to keep up with the rest of the medical care delivery system . . . "If not corrected, there is a strong possibility that we will not accept any new DSSH patients at all . . . " **John Keenan** of the Physicians Action Group called the present level of Medicaid funding "totally inadequate . . . Presently the majority of the physicians in the State cannot accept many Medicaid patients. Most of the major clinics will see only a very small percentage of this type of patient . . . " The Straub Clinic wrote that although their facility limits the number of Medicaid patients accepted, "In 1975, we wrote off $238,400 in bad debts and allowances to medicaid patients." Other letters came from the Fronk Clinic, Chock-Pang Clinic, Windward Medical Center, Leeward Clinic, and the Pang Eye, Ear, Nose and Throat Clinic. DSSH Director Andrew Chang favors raising the reimbursement rate for doctors participating in the Medicaid program. He estimates that it would cost an additional $4-million to raise the reimbursement to 100% of the doctors' usual and customary charges. The DSSH's projected cost for all professional services for 1976-1977 fiscal year is $22,459,071 based on the proposed reimbursement. Roughly $13-million would come from State funds and $9.5-million from Federal funds . . .

The State Board of Acupuncture reversed its course again in late December and adopted rules allowing acupuncturists to treat only a limited number of ailments . . . Earlier in December, the board voted to permit acupuncturists to treat any medical problem except for six ailments *viz* cancer, open wounds, heart attacks, bone fractures or concussion, incurable disease or venereal disease. The original rules had allowed treatment only for pain relief and functional disorders and prohibiting the treatment of organic disorders unless first authorized by a medical doctor. Now the new ruling is that acupuncturists can treat for pain relief and analgesia and functional disorders including functional components of diseases and abnormal conditions . . . (Whatever that means . . .)

The Marathon and Physicians

By Egerton Y. Davies, M.D.

About 25 miles from Athens lies the plain of Marathon. It was at this place in 490 B.C. that the Athenians assembled to stop the advancing army of Darius, the king of Persia. Outnumbered by the Persians two to one, the Athenians sent a swift runner, Pheidippides, to Sparta, 150 miles away to summon aid. But the Spartans were engaged in religious observances, and Pheidippides returned empty-handed.

The Athenian general, Miltiades, attacked the Persians, nonetheless, with a running charge, and the speed, superior weapons, and bodily strength of the Greeks gave them a resounding victory. The Persians lost 6,400 men and were driven back to their ships. The Athenians lost only 192.

As the Persian ships sailed away, Miltiades was concerned that this fleet might attack Athens by sea, and that the city might capitulate, not knowing of the victory at Marathon. Consequently, he sent Pheidippides, still weary from his run to Sparta, on a race to Athens to notify the city-state of the Marathon triumph. The runner covered the distance, a little more than 26 miles, at a rapid pace, and on reaching the city, cried out "Rejoice, we conquer," and then fell dead on the ground.

Using the distance from Marathon to Athens, Marathon races have been popular for many years, especially in Boston and at the Olympic Games. The third Annual Honolulu Marathon was held on December 14, 1975, and attracted more than 700 entrants. Many contestants, particularly those from the Honolulu Marathon Clinic, entered the race as a logical consequence of a regular jogging program.

Among local physicians competing were the following: **Gallup, Dierdorff, Keller, Scaff, Spallek, C. Akina, Stodd, Frankel, Sroat, Di Mauro, Roth, H.H. Chun, Lockwood Young, Rosen, A. Morris, Atienza, O. Kaneshiro, Uemura, J. Bennett, S. Berman, Mundt, Tucker, Carlson, May, Starbuck, Wagner,** and **J. Harrison.** Medical students included **Duncan MacDonald** (1973 winner), **Sakima, Kunz, Markham,** and **Ryan.** (If any physicians or students were left out of this list, it was an oversight for which the writer apologizes.)

Interest in running is high, and future marathons here hold a promise of attracting even greater numbers of entrants. It is said that after you have been jogging for a year, you are hooked.

Something Smells?

We congregated at the same dining table for the Bylaws Committee meeting. Nuclear med man **Dick Warsnick** and radiologist **Don Ikeda** were discussing a problem. Dick asked, "How would you handle this problem?" and explained how an immigrant employee in his department exudes B.O. and will not use a deodorant. In fact, several patients had walked out during their nuclear studies because of the overpowering odor . . . We recommended a direct approach and explained that one becomes immune to his own B.O. . . . Don agreed and explained how he had told someone about his B.O. and that person had appreciated the information . . . **George Kimata** turned to Kuakini Hospital VP **Ron Oba** and suggested that Ron could handle the task with the utmost delicacy since he was so charming . . . **Clarence Sugihara,** Bylaws Committee chairman, suggested that we introduce a clause in the Bylaws that evey hospital employee take a daily shower and use ample deodorant . . . Dick was for using a ruse whereby several cans of deodorant be left in the women's restroom and a fellow employee could suggest a trial use . . . We preferred referral to a dermatologist to check if she had trichomycosis axillaris and if she did not, then the physician could suggest the use of deodorants . . . Dick thanked us for all the helpful suggestions and moral support and strode forth, chin out and a determined gleam in his eyes . . . We wished him luck . . . Just then we began to wonder . . . Why did they broach the subject of B.O. just as we had joined them? Hey, fellows! Wait a minute . . .

Our "Angels"

Page

Higuchi Insurance Agency, Inc. 91

Eli Lilly and Company
Kefzol 82

The Medical Center 93

McNeil Laboratories, Inc.
Tylenol 78

Pharmaceutical Manufacturers
Association 80, 81

Roche Laboratories
Valium 76, 77

Westwood Pharmaceuticals, Inc.
Presun 98

Williams Mortuary 92

PreSun

(5% PABA LOTION)

may help prevent harmful effects of the sun such as premature aging of skin and skin cancer.*



*Information on file at Westwood Pharmaceuticals Inc.

WESTWOOD
PHARMACEUTICALS INC.
Buffalo, New York 14213

©1974, W. P. Inc.

APRIL, 1976
VOL. 35, NO. 4

Hawaii Medical Journal

CONTENTS

Phenelizine and Psychosis 109
Leonard S. Jacobs, M.D., Richard A. Green, M.D., J. Christian Gillin, M.D., and Richard J. Wyatt, M.D.

Announcement 103

Clinical Pathologist's Easy Chair 116

Continuing Medical Education 117

Editorials 113

Hawaii Academy of Family Physicians' Newsletter 125

HMA Council Meeting 115

HMA Newsletter 112

New Members 114

News & Notes 119

The Library SP
Acquisitions Division
University of California, San Francisco
San Francisco California 94143

LIBRARY
U.C. SAN FRANCISCO
MAY 19 1976

Both often



Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequenc and/or severity of grand mal seizures ma require increased dosage of standard ant convulsant medication; abrupt withdrawa may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuanc (convulsions, tremor, abdominal and mus cle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium®
(diazepam) Ⓡ IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

PreSun

(5% PABA LOTION)

may help prevent harmful effects of the sun such as premature aging of skin and skin cancer.*



*Information on file at Westwood Pharmaceuticals Inc.

WESTWOOD
PHARMACEUTICALS INC.
Buffalo, New York 14213

©1974, W. P. Inc.

Hawaii Medical Journal

Published Monthly by the
HAWAII MEDICAL ASSOCIATION
(Incorporated in 1856 under the Monarchy)
510 S. Beretania St., Honolulu, Hawaii 96813

EDITORS

Editor, HARRY L. ARNOLD, JR., M.D.
News Editor, HENRY N. YOKOYAMA, M.D.
Assistant Editor, DORIS R. JASINSKI, M.D., M.P.H.
Contributing Editor, ROBERT H. MOSER, M.D.
Contributing Editor, J.I. FREDERICK REPPUN, M.D.
Book Review Editor, WINFRED Y. LEE, M.D.
Executive Editor, PAUL STEWARD

OFFICERS

President, WILLIAM W.L. DANG, M.D.
President-Elect, CALVIN C.J. SIA, M.D.
Past President, WINFRED Y. LEE, M.D.
Secretary, R. VARIAN SLOAN, M.D.
Treasurer, GROVER H. BATTEN, M.D.

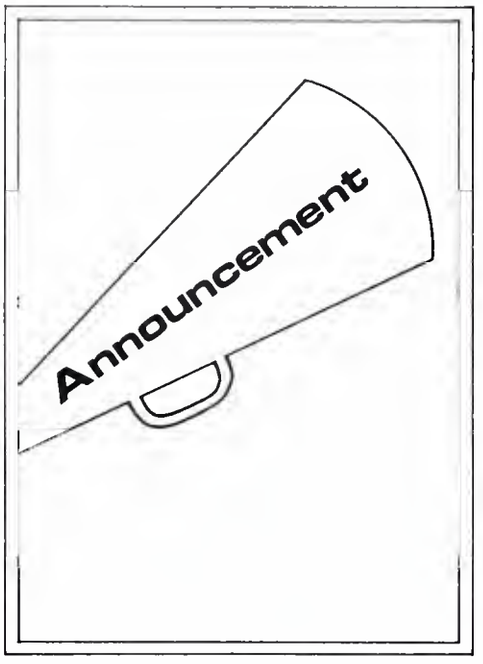
County Presidents

Hawaii, KENNETH HUGHES, M.D.
Honolulu, DOUGLAS B. BELL, II, M.D.
Kauai RIEAZI REMITIO, M.D.
Maui, CLIFFORD MORAN, M.D.
Delegate to AMA, GEORGE H. MILLS, M.D.
Alternate Delegate to AMA,
HERBERT Y.H. CHINN, M.D.

Advertising Representatives
National:
HAWAII MEDICAL ASSOCIATION
510 S. BERETANIA STREET
Honolulu, Hawaii 96813
Phone (808)536-7702
Honolulu:
LILITH JURRY, Phone 946-0053

THE JOURNAL may not be held responsible for opinions expressed in papers, discussions, communications, or advertisements. The advertising policy of the HAWAII MEDICAL JOURNAL is governed by the rules of the Council on Drugs of the American Medical Association. The right is reserved to reject material submitted for editorial or advertising columns. All material for publication must be in the hands of the editor on or before the 10th day of the month preceding publication date. Reprints of original articles will be supplied at actual cost. A reasonable number of illustrations accompanying an article will be accepted for printing. The right is reserved to ask the author to bear cost of these when it is found necessary to do so.

Copyright, 1976 by the Hawaii Medical Association, Honolulu, Hawaii. 2nd class postage paid at Honolulu, Hawaii. Office of Publication: Mabel L. Smyth Memorial Building, 510 S. Beretania St., Honolulu, Hawaii 96813.



The Seventh Hawaii Emergency Physicians Seminar, will be held in the Pacific Building Auditorium of Kaiser Hospital on May 16-17, repeated on May 18-19. Sponsored by the HMA/EMS Program and the Hawaii Chapter of the American College of Emergency Physicians 8:00 a.m.—4:00 p.m., 12 hours credit. Registration—$5.00 per day. Preregister in writing by May 1. Contact: J. K. Sims, M.D. at 538-9011, extension 471.



"Are you in a rush for this?"



Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct nontherapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

P·M·A
Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005

A NON-ASPIRIN ALTERNATIVE TO COMPOUND ANALGESICS

Documented potency: Double-blind clinical studies[1,2,3] demonstrate the efficacy of TYLENOL® acetaminophen Extra-Strength capsules (500 mg.) in the control of moderate to severe pain.†

No aspirin side effects: Unlike most compound analgesics, TYLENOL Extra-Strength capsules contain no aspirin; they therefore minimize the risk of side effects often associated with aspirin, such as gastric irritation, hemostatic disturbances and allergic reactions.

So when your patients with minor conditions need greater analgesic strength than that provided by regular doses of the mild analgesic products, recommend or prescribe TYLENOL Extra-Strength capsules.

1. Hopkinson, J.H. III, et al.: Curr. Ther. Res. *16*:194 (Mar.) 1974.
2. Berry, F.N., et al.: Curr. Ther. Res. *17*:361 (Apr.) 1975.
3. Smith, M.T., et al.: Curr. Ther. Res. *17*:452 (May) 1975.

Precautions and Adverse Reactions: If a rare sensitivity reaction occurs, the drug should be stopped. TYLENOL® acetaminophen products have rarely been found to produce any side effects.

Available in bottles of 50.

†Episiotomy was used as a model to evaluate analgesia.

Recommend or prescribe 2 caps t.i.d. or q.i.d.*

*No more than a total of 8 capsules in any 24-hour period.

© McN 1976

McNEIL McNeil Laboratories, Inc., Fort Washington, Pa. 19034

TYLENOL® acetaminophen EXTRA-STRENGTH CAPSULES 500 mg.



We're the only lab in the islands affiliated with Bio-Science.

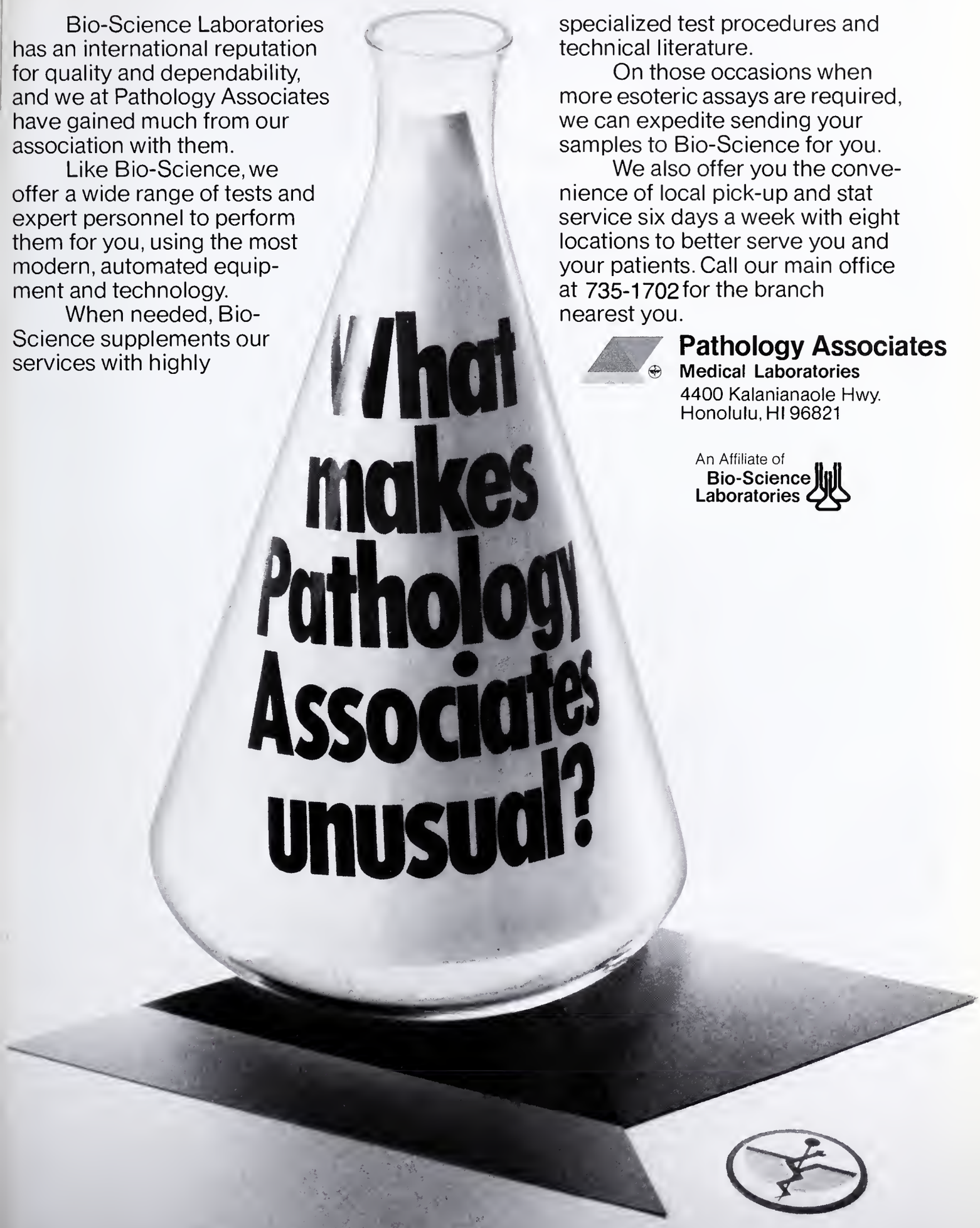
Bio-Science Laboratories has an international reputation for quality and dependability, and we at Pathology Associates have gained much from our association with them.

Like Bio-Science, we offer a wide range of tests and expert personnel to perform them for you, using the most modern, automated equipment and technology.

When needed, Bio-Science supplements our services with highly specialized test procedures and technical literature.

On those occasions when more esoteric assays are required, we can expedite sending your samples to Bio-Science for you.

We also offer you the convenience of local pick-up and stat service six days a week with eight locations to better serve you and your patients. Call our main office at 735-1702 for the branch nearest you.



Pathology Associates
Medical Laboratories
4400 Kalanianaole Hwy.
Honolulu, HI 96821

An Affiliate of
Bio-Science Laboratories

Kefzol®
cefazolin sodium

Ampoules, equivalent to 250 mg., 500 mg., 1 Gm., and 10 Gm. of cefazolin



Lilly

Additional information available to the profession on request.

Eli Lilly and Company
Indianapolis, Indiana 46206

600062

Phenelizine and Psychosis

LEONARD S. JACOBS, M.D.*, RICHARD A. GREEN, M.D.**,
J. CHRISTIAN GILLIN, M.D.**, *and* RICHARD J. WYATT, M.D.†, *Honolulu*

Though normally effective in treating depression, monoamine oxidase inhibitors (MAOI) have also been reported to exacerbate the clinical state of some depressed and schizophrenic patients [1,2,3] *These reactions have included increased depression, psychotic symptoms, and acute brain syndrome (delirium). Common to most descriptions of these toxic effects of MAOI have been defective reality testing, vivid visual and auditory hallucinations, poor attention span, verbigeration, tremulousness, and insomnia. These unfavorable responses abate within five to ten days following discontinuation of the medication.*

We had occasion to observe such a toxic reaction to phenelzine (an MAOI) in an anxious depressed woman while we were physiologically monitoring her sleep. Previously we and others had demonstrated that rapid eye movement (REM) sleep is suppressed by MAOIs and that at least some depressed patients improve concomitant to this REM suppression [4,5,6]. In the present patient, the MAOI not only suppressed REM sleep, but also disrupted non-REM (NREM) sleep, producing a period of total insomnia as her mental status worsened to delirium. Cessation of the phenelzine lead to a dramatic improvement in her mental status and restored her sleep toward predrug levels.

CASE REPORT

Mrs. M., a 48-year old housewife and mother, was admitted to a National Institute of Mental Health research wars with a history of agitated crying outbursts and threats of suicide. Previous treatments for these episodes included hospitalization, ECT, and drugs. She had been prescribed tranylcypromine, imipramine, thyroid compounds, phenothiazines, methylphenidate and diazepam. Physical and laboratory examinations were normal.

At the time of her admission, the patient was a timid, frightened, dependent woman suffering from moderate depression and anxiety, with only limited psychological insight. There was no evidence or history of delusion, hallucinations, nor thought disorder suggestive of psychosis. She was oriented as to person, place and time. Her intelligence, fund of information, and cognitive performance were average. She complained of constipation, fatigue, and insomnia. Because of her depression, she was placed on phenelzine (Nardil).

When placed on phenelzine, she appeared to be developing a psychotic depression. Unfortunately, while receiving the phenelzine, the patient worsened, gradually becoming delirious (acute organic brain syndrome) and psychotic. She had intense auditory and visual hallucinations, became disoriented as to person, place, and time, and occasionally bumped into objects as if she were blind. She became agitated, and at times clung to people, moaning, or declaring that she was a "monster" who needed punishment. She also expressed nihilistic delusions, believing all around her were dead, and fearing that she had killed her children because she had told them she did not love them. She ignored her personal hygiene, grimaced, and made swimming movements with her arms, displayed echolalia and verbigeration, and was frequently totally unresponsive to people around her.

When the phenelzine was discontinued, her agitated delirium rapidly abated. The next day she was quiet, well groomed, ate appropriately with the other patients, and seemed more aware

* Head, Kalihi-Palama Community Mental Health Center
Mental Health Division, Department of Health
810 No. Vineyard Boulevard
Honolulu, Hawaii 96817

** Laboratory of Clinical Psychobiology
National Institute of Mental Health, Building 10, Room 3N262
900 Rockville Pike, Bethesda, Maryland 20014

† Laboratory of Clinical Psychopharmacology, Division of Special Mental Health Reasearch, IRP, National Institute of Mental Health, Elizabeths Hospital, Washington, D.C. 20032

Accepted for publication July 1, 1975.

of her surroundings. The third day after discontinuation of the phenelzine, she began to converse with people, exploring with them her recent experiences. She declared that the events of the past month seemed "like a dream.." She reported having vivid dreams for the next few days, which she thought her therapist knew about. She also reported that she was having difficulty initiating movements or "gathering" her thoughts, complained of popping noises in her head, and felt sensations or "rushes" going up her body into her head. She continued to have auditory hallucinations and ideas of reference for the next week. Enlisting the aid of the staff she began making plans for rehabilitating herself and going home. Within two weeks, however, she settled back into her negativistic and complaining mode of interacting with others.

METHODOLOGY

Throughout her hospitalization, the patient's EEG, electrooculogram and electromyogram were monitored nightly while she slept in her own hospital bed. These polygraphic sleep recordings were then scored by standard criteria by a person unaware of the patient's drug status [7]. At the same time, the patient's behavior and mood were rated by the nursing staff on a 14-symptom rating scale shown to have high inter-rater reliability [8]. Five items from the scale (form of speech, hallucinations, delusions, paranoia, and bizarre behavior) were combined to form the psychosis ratings reported here. Figure 1, using two day means, graphically illustrates the behavioral ratings, minutes of REM and NREM sleep, and the course of dosage of medication.

Results

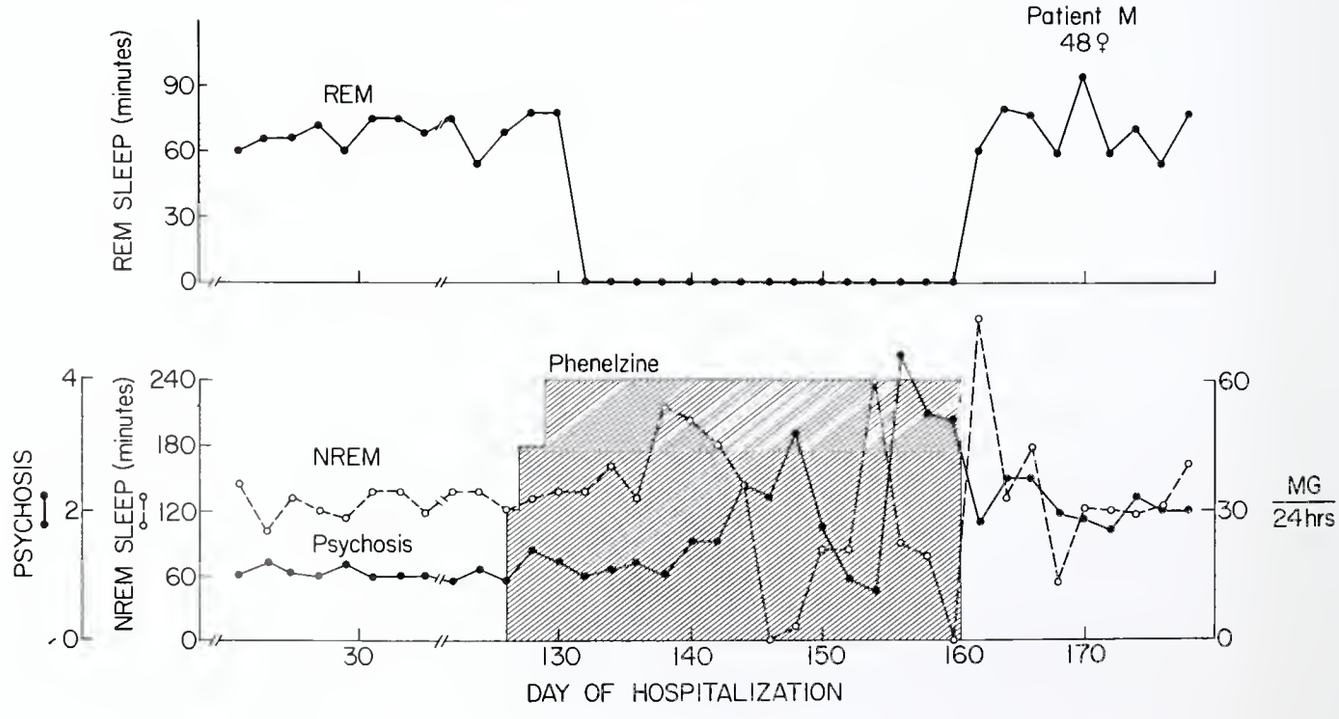
During the baseline period, total sleep (REM & NREM) averaged 226 ± 74 minutes (mean ± SD). On phenelzine, the mean total sleep fell to 120 ± 93 minutes ($P < .005$, two-tailed "t" test). The mean NREM sleep during baseline was 161 ± 62 minutes. On phenelzine her mean NREM sleep fell to 120 ± 93 minutes ($p < .05$). The mean REM sleep decreased from a baseline of 59 ± 10 minutes to zero on phenelzine ($p < .001$). She had virtually no stage 3 or 4 sleep either on or off phenelzine. While REM sleep returned to baseline following discontinuation of the phenelzine, there was no REM sleep rebound. A product-moment correlation between the psychosis ratings and the amount of NREM sleep was 0.427 ($p < .01$).

Discussion

The anxious-depressed patient described here responded idosyncratically to phenelzine treatment. While never previously psychotic, she developed hallucinations and delusions in addition to a confusional state usually associated with an organic brain syndrome. Concomitant with psychosis, there were marked changes in the patient's sleep. The phenelzine totally suppressed REM sleep and markedly decreased NREM sleep.

During the late 1950s and early 1960s, a hypothesis developed that REM sleep suppression leads to psychiatric disturbance including psychosis. Subsequent studies have not substantiated this initial impression, although subtle detrimental psychological changes may take place.[9-15] On the other hand, a significant number

FIGURE 1:—*Nurses behavior rating scale on a 0-7 scale, NREM sleep in minutes, REM sleep in minutes, and phenelzine in mg./24 hours presented in two-day means from top to bottom.*



of depressed patients improve concomitant to REM suppression.[4]

The simultaneous MAOI disruption of NREM and suppression of REM in depressed patients has not previously been reported. It would appear that the disruption of NREM sleep is more related to the production of psychosis than that of REM sleep and is evidence of the high inverse correlation between NREM and the psychosis rating. Stage 4 sleep deprivation has been reported to produce fatigue, depression, and reduced functioning. Since there was no appreciable stage 3 or 4 sleep prior to phenelzine administration, the behavior changes seen in this patient cannot be explained through stage 4 deprivation. Little has been done to determine the effects of total sleep deprivation in depressed patients but it is of some interest that there is at least one report of sleep deprivation of one night causing subsequent improvement in depressed patients.[16]

Unlike the majority of non-schizophrenic subjects, chronic active and acute schizophrenic patients frequently fail to have a REM rebound following relatively profound REM deprivation. It may be that this patient's particular spectrum of depression was related to a similar pathophysiology of the schizophrenics who failed to have REM rebounds. Perhaps the mechanisms which normally supress REM associated events from breaking into NREM[18] and waking in this patient were not able to function under the added pressure of total RDM suppression, and thus disturbed both her NREM and waking life.

Summary

Administration of monoamine oxidase inhibitors (MAOI) to depressed patients, while usually beneficial, is occasionally associated with the development of psychotic reactions. Daily administration of high dosages of MAOIs also abolishes polygraphic evidence of rapid eye movement sleep (REMS) and may produce insomnia. Presented is a case report of a depressed woman who became insomniac, delirious, and psychotic when given phenelzine, an MAOI. The patient's insomnia improved following discontinuation of the phenelzine, and her psychosis rapidly abated. Her sleep was recorded throughout. The relationship of non-rapid eye movement sleep disturbances to the exacerbation of affective and schizophrenic disorders is discussed.

REFERENCES

1. Clarke J: Side-effects of phenelzine. *Br Med J*, 1: 1204, 1960.
2. DiMascio A, Shader RI: Behavioral toxicity. In: D. H. Efron (ed), *Psychopharmacology: A review of progress, 1957-1967.*, Bethesda, U. S. Public Health Service Publication No. 1836, 1968.
3. Johnson J, Eilenberg MD: Psychotic reactions and phenelzine (Nardil). *Br Med J*, 2:857-858, 1960.
4. Akindele MO, Evans JI, Oswald I: Monoamine oxidase inhibitors, sleep, and mood. *Electroenceph Clin Neurophysiol*, 29:47-56, 1970.
5. Wyatt RJ, Fram DH, Kupfer DJ, et al: Total prolonged drug-induced REM sleep suppression in anxious-depressed patients. *Arch Gen Psychiat*, 24: 145-155, 1971.
6. Wyatt RJ, Kupfer DJ, Scott J, et al: Longitudinal studies of the effect of monoamine oxidase inhibitors on sleep in man. *Psychopharmacologia*, 15: 236-244, 1969.
7. Rechtschaffen A, Kales A: *A manual of standardized terminology, techniques, and scoring system for sleep stages of human subjects.* Bethesda, U.S. Public Health Service Publication No. 204, 1968.
8. Wyatt RJ, Kupfer DJ: A fourteen-symptom behavior and mood rating scale for longitudinal patient evaluation by nurses. *Psychol Rep*, 23: 1331-1334, 1968.
9. Vogel GW, Traub AC: REM deprivation, I. The effect on schizophrenic patients. *Arch Gen Psychiat*, 18: 287-300, 1968.
10. Vogel GW, Traub AC, Ben-Horin P, et al: REM deprivation. II. The effects on depressed patients, *Arch Gen Psychiat* 18: 301-311, 1968.
11. Zarcone V, Gulevich G, Pivik T, et al: Partial REM phase deprivation and schizophrenia. *Arch Gen Psychiat* 18: 194-202, 1968.
12. Agnew Jr, HW, Webb WB, Williams RL: Comparison of stage four and 1-REM sleep deprivation. *Percept Motor Skills* 24: 851-858, 1967.
13. Clemes SR, Dement WC: Effect of REM sleep deprivation on psychological functioning. *J Nerv Ment Dis*, 144: 485-491, 1967.
14. Fisher C: Psychoanalytic implications of recent research on sleep and dreaming. *J Amer Psychoanal Ass*, 13: 197-303, 1965.
15. Kales A, Hoedemaker FS, Jacobson A, et al: Dream deprivation: an experimental reappraisal. *Nature* 204: 1337-1338, 1964
16. Pflug B, Tolle R: Therapy of endogenous depressions by sleep deprivation: practical and theoretical consequences. *Der Nerv Nart*: 42: 117-124, 1971.
17. Kupfer DJ, Wyatt RJ, Scott J, et al: Sleep disturbance in acute schizophrenic patients. *Amer J Psychiat* 126: 1213-1223, 1970.
18. Dement WC, Zarcone V, Ferguson J, et al: Some parallel findings in schizophrenic patients and serotonin-depleted cats In: D.V. Siva Sankar (ed.), *Schizophrenia, current concepts and research.* Hicksville, N.Y., PJD Publication Ltd., 1969, p. 775-811.



H. Tom Thorson

Computer Complex—For years HMA has engaged in a running battle with the Bureau of Health Insurance, Social Security Administration over the use of the California Relative Value Study of 1964, as the audit document for claims for Medicare in Hawaii. Protests have been unavailing and responses to the protests have been pure *shibai*. Recently we have been advised that BHI is "updating" and now will use the 1969 California RVS. Just possibly they will go to the 1974 California RVS. Big deal! Just what the California RVS has to do with the pattern of practice in Hawaii is unknown to us. California has done a magnificent job in their RVS, but it does relate to California and not necessarily to Hawaii, although we have benefitted greatly from their experience.

BHI's sole justification is that the computerization of codes and procedures makes it mandatory that only one schedule be used. This is the route to take to a national fee schedule. In other words the profession works for the computer; the computer doesn't work for the profession.

AMA Meeting—The annual meeting of the AMA will take place in Dallas, Texas, June 26-July 2, 1976. Resolutions for consideration by the House of Delegates must be submitted to the AMA not later than May 26, 1976.

Program details are published in JAMA and registration forms are included. If you intend to go to the meeting, you should register as early as possible because hotel space will be scarce.

Attending from HMA will be Drs. George Mills, Herbert Chinn, as delegates, Drs. Varian Sloan and Bill Dang as alternate delegates, Dr. George Mills is a candidate for the office of trustee of the American Medical Association.

Other State Licenses—If you are licensed in other states and wish to maintain that license, you are advised to communicate with those states immediately relative to revised requirements concerning continuing medical education. Many states have instituted mandatory education as a relicensing criterion. In all probability the current legislature in Hawaii is going to do the same. The state of Washington has advised that they will hold a hearing on rules and regs on April 23, 1976— Olympic Hotel, Seattle, at 1:30 PM. Fifty hours of CME will be required per year.

Michigan is another state going that route. We will list them as the information is available.

Hawaii Legislature is still in session as this is written. The omnibus malpractice bill will go to joint conference. The legal beagles in the legislature have worked hard to avoid any controls on the legal profession but want rigid controls on the medicos. In some ways they seem to want a free hand to rip off the patient and the doctor alike. We hope that the joint conference will iron out some of the wrinkles—all we can do now is hope for the best and depend on some of our friends in the legislature.

Alcoholics will find a new facility in Hilo. Hilo Care Center will accept referrals beginning April 5, 1976. The facility fills a gap in alcoholic treatment providing for definitive treatment and follow up program. Address— Hilo Care Center, 944 West Kawailani Street, Hilo, Hawaii 96720— Phone 949-9151.

Dues Are Overdue—If your dues have not been paid by March 31, you are delinquent, and if not paid by May 1, membership will be cancelled. This is according to the bylaws.

DSSH Fee bill, requiring the DSS to pay the maximum fee allowable under federal regs, appears likely to be law by the time you read this. At the time of writing, we see no obstacles.

DSSH new regulations relative to advance authorization are totally unworkable as written. No testimony was presented at the hearing in Honolulu, but the Kauai Medical Society did a wonderful job of pointing out the deficits in the proposed regs. It is hard to understand the motives and purposes of the DSS administrators when they point one way and run another.

We were pleased to find that the GAO is doing a management audit of the DSS program. Maybe we can find out what is going on.

Dang Plan—Questions were raised relative to the delinquency date for initial Dang Plan deposits. The Council voted to establish December 31, 1976, as the delinquency date. This is done primarily to accommodate those that select option three, paying ten dollars per month install-

ments for ten months.

AUTO-PLUS Insurance Experience—Correspondence recently received from Pacific Insurance invites attention to HMA's group auto insurance experience developed in 1975 which showed an earned premium of $16,897 and losses of $13,252. This produced an overall loss ratio of 78.4%. In reviewing their large losses, they find that they had no record of any in excess of $5,000. Therefore, they must assume that the losses are attributed to frequency. Further, the cumulative experience from the inception of the contract shows that they have produced an earned premium of $17,272 and losses of $16,903. This produces an overall account loss ratio of 97.8%.

They are concerned with the poor experience and feel that for them to continue, improvement must be noted. Therefore, they will make another review after June to determine if an acceptable loss ratio is developing.

Air Force Positions open—The Air Force wishes to recruit doctors in virtually all specialties. Persons interested—contact Kenneth J. Mackie, Jr., Captain, USAF, MSC. Medical Personnel Procurement Officer, 620 Central Avenue, Alameda, Cal. 94501.

Applications invited for Associate Medical Director, a major life insurance company in Southern California. Man or woman with specialties confined to CD, GP, GPM. IM, OM or PD. Salary open. Contact E.R. Hergenrather, Consultant, Suite 2128, 3435 Wilshire Blvd. Los Angeles, 90010 or (213) 385-0181.

West Coast Allergy Society will hold its 15th Annual Scientific Program, October 7, 8, 9, 1976, in Washington Plaza Hotel, Seattle. For further information contact— William H. Wilson, MD. West Coast Allergy Society, 2164 S.W. Park Place, Portland, Oregon 97205.

American Board of Family Practice will hold next certification examination October 30-31, 1976, in seven cities throughout the US. Contact Nicholas J. Piscano, MD. Executive Director, American Board of Family Practice, Inc., University of Kentucky Medical Center, Lexington, Kentucky 40506. Deadline date is June 15, 1976.

American Association for Clinical Immunology and Allergy will hold its annual scientific session November 28-December 2, 1976, in the Braniff Place Hotel, Tucson, Arizona. This is a change and other dates are cancelled. Contact Howard Silber, Exec. Dir., P. O. Box 912, Omaha, Nebraska 68101.



Yes, We Are All Too Busy

"Doctor, your waiting room is so full; how can you be involved in all these other things as well?"

"Yes, Ma'am. Perhaps I should have my head examined!"

Last month we listed a physician's extra-curricular activities: a) self-care; b) CME; c) organized medicine, all the way from hospital medical staff work to medical society, state and national professional exercises; and d) non-professional community service. We mentioned the professional man who even gives up his practice in order to go into politics, noting that most of his patients tolerate his extra-curricular activities up to this point, but complain when he makes himself conspicuously unavailable when they need him as a physician.

So, what else can draw the busy practitioner's interest during his off-hours?

What about his family? The doctor's family usually occupies a place far down the list of priorities. A good spouse realizes early in their marriage, yes even before his career has started, that there will be a *menage a trois* forever in his career life, the third party (medicine) being one of the most exacting mistresses ever. Still, a doctor's family can be a reflection of himself in relation to his patients; many a wife, daughter, mother or sister plays the role of the doctor's mouthpiece.

Then there is recreation — something all sane men and women need. Golf, sailing and what have you. The doctor is usually never far away, always within phone call, often finding his fun interrupted. As for vacations, they are often tied in with CME, the combination luring him away from the insistent telephone by putting miles between; his family often goes along, for obvious reasons. But, many physicians never have recreation nor take vacations.

Isn't this list long enough? It should be, but it isn't. There is one additional activity, intra-

rather than extra-curricular, newly compulsory. It is mandatory peer review and mandatory medical audit.

The professions finds nothing new in either of these exercises. In fact, they were initiated by us long since, as a self-policing, usually gentle and compassionate mechanisms for education within hospitals and clinics. With the advent of government as a third party and fiscal agent, however, so-called "peer review" has become "cost control", and has turned nasty. Worst of all are the mandatory medical audits — so many each quarter — based on cold statistics and projecting faceless "providers" as against victimized "consumers".

Nearly fifty years ago it was the New Deal's WPA — Works Progress Administration — the acronym for "make work". Unemployed people were hired to rake leaves from here to there and back. Today it is QUAP — Quality Assurance Program — another make work scheme, except that there are no unemployed in medicine. On the contrary, the worker in medicine, the practitioner, is already overwhelmed with patient-care. To ask him; nay, to force him to work extra in cost control, and in silly medical audits, is to drive physicians into the arms of their head-shrinking colleagues.

"PAS/MAP shows that too many antibiotics are being used in this hospital. Shape up, you guys!"

Auwe!

J. I. F. R.





Judith C. Begley, M.D.
Department of Pathology
John A. Burns School of Medicine
University of Hawaii
Honolulu, Hawaii 96822
PATHOLOGY



Patrick J. Donley, M.D.
Tripler Army Medical Center
P. O. Box 163
APO, San Francisco 96438
PSYCHIATRY



Robert C. Flair, M.D.
888 South King Street
Honolulu, Hawaii 96813
PATHOLOGY



Paul Y. K. Lin, M.D.
99-185 Moanalua Road
Aiea, Hawaii 96701
GENERAL PRACTICE



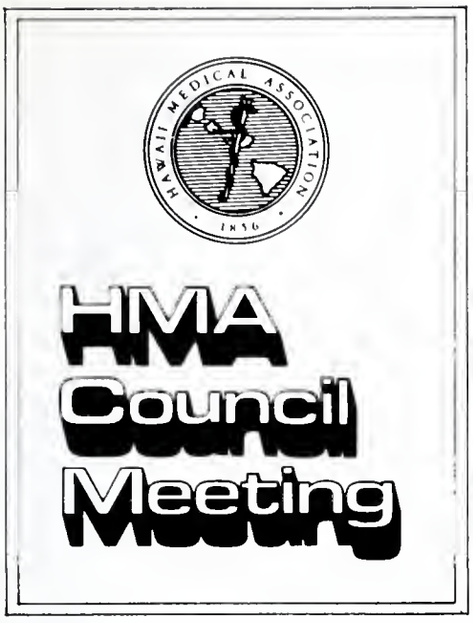
Patrick C. Lowry, M.D.
C/O MEDEX
University of Hawaii School of Medicine
Honolulu, Hawaii 96822
FAMILY PRACTICE



Alfred G. Scottolini, M.D.
1697 Ala Moana Boulevard
Honolulu, Hawaii 96815
PATHOLOGY



Fay B. Weinstein, M.D.
Naval Communications Station
FPO, San Francisco 96613
GENERAL PRACTICE



January 16, 1976, 5:30 P.M.
Mabel Smyth Lanai

CALL TO ORDER

The meeting was called to order by President William W. L. Dang. Present were Drs. Calvin C. J. Sia, Winfred Y. Lee, R. Varian Sloan, Grover H. Batten, George H. Mills, Herbert Y. H. Chinn, Ann B. Catts, George Goto, Rowlin Lichter, J. 1. F. Reppun, Arnold Siemsen, Sakae Uehara, Peter Kim, Douglas Bell II, Clifford Moran, and Rienzi Remitio. Drs. William Moore and Roy Kuboyama were seated as councillors pro tem for Drs. Kim and Lum. Also present was Mrs. Alice Tucker, Auxiliary President.

MINUTES

The minutes of the Special Council Meeting of December 12, 1976 were amended as follows: A budget of $500 was allocated for the HMA support of the candidacy of George H. Mills, M.D. for the AMA Board of Trustees.

ACTION:

It was voted to approve the minutes as amended.

SECRETARY'S REPORT

The report of the secretary was approved as circulated.

TREASURER'S REPORT

The financial statement for November 1975 was circulated and reviewed.

ACTION:

It was voted to approve the November 1975 statement subject to audit.

ELECTIONS

A. Community Research Bureau: Dr. B. Allen Richardson called the annual meeting of the Community Research Bureau to order and reviewed the activities of the bureau for the previous year. Officers were nominated and elected as follows: B. Allen Richardson, President; Theodore T. Tomita, Vice President; O. D. Pinkerton, Secretary; and Grover H. Batten, Treasurer.

B. Hawaii Foundation for Medical Care: Trustees to the Hawaii Foundation for Medical Care were nominated and elected for three-year terms as follows: Ann B. Catts, Henry T. Oyama, and Winfred Y. Lee.

C. HAMPAC: Dr. L. Q. Pang, President of the Board of Directors of HAMPAC, urged the Council to encourage the HMA membership to join HAMPAC, especially in view of the crucial legislation facing the medical profession in the coming months. Dr. Mills noted that as a former recipient of HAMPAC funds he was very grateful for the support he received from the Political Action Group.

ACTION:

The HMA President was directed to appoint the HAMPAC Board as quickly as possible.

REPORT OF THE COMMISSIONS AND COMMITTEES

A. Internal Affairs: Dr. Sloan reported that the Convention Committee met and made preliminary plans for the 1976 annual meeting which will be held at the Ilikai Hotel, October 25-29, with the theme "Global Medicine and Diseases of Travel." The following recommendations were approved:

ACTION:

1) **The House of Delegates will meet on Wednesday and Friday afternoons, October 27 and 29.**
2) **Registration fee for non-members: $100.**
3) **Fees for HMA members, interns, residents, medical students, paramedical personnel and guests will be waived.**
4) **A travel agency will assist with mainland participants schedules.**
5) **Commercial exhibits will be charged $250 per booth. Scientific exhibits will be permitted with no fee subject to committee approval.**
6) **A fee will be charged for postgraduate courses, the amount to be recommended by the Scientific Committee and approved by the Council.**

B. Medical Education: Dr. Lee reported that most of the major hospitals in the State have been accredited by the HMA's Medical Education Committee and are now offering accredited CME courses. The committee is presently reviewing the AMA's Physician's Recognition Award and considering possible alternatives. The committee has also discussed the role of the HMA in developing CME programs.

ACTION:

It was voted to accept the recommendation that the HMA participate and take an active role in developing or helping to develop CME programs and that the HMA directly participate when necessary.

C. Peer Review: Dr. Catts reported that the committee is considering a report to the Bar Association regarding frivolous cases. It was recommended that the Interprofessional Relations Committee be asked to study the report.

D. Public Affairs: The Tel Med program, a telephone health education program for the public was implemented in December. The HMA will review all tape messages, ads, TV publicity, etc. via an Operations Committe which has two HMA representatives and two HMSA representatives. A contract between HMA and HMSA for the operation of the Tel Med program was presented for Council approval.

ACTION:

It was voted to instruct the President to sign the contract. There were three opposing votes.

E. Legislation: A public relations campaign on the subject of medical malpractice insurance was outlined for the Council. Dr. Goto noted that the Legislative Committee budget is sufficient to cover the cost of the campaign if Council will permit the reallocation of some of the funds. Approval was given. Mrs. Tucker was asked to work with the committee in designing brochures on this subject.

ACTION:

The Executive Committee was authorized to review the campaign and approve the budget for the program.

It was also noted that a new lobby registration law is in effect and anyone who speaks on behalf of the Association must be registered. Forms are available in the HMA Offices. A copy of the Omnibus bill and a proposed voluntary arbitration agreement were circulated.

F. EMS: Dr. Sia reported that the EMS program has been the subject of recent press and television coverage. He requested Council approval to meet with the press and outline the role of the HMA in the development of the EMS project.

ACTION:

Dr. Sia was given approval to meet with the press regarding the role of the HMA in the EMS program.

G. PL 93-641: HMA has received word that the request of Governor Ariyoshi for an exemption from designating health services areas for Hawaii under PL 93-641 was approved by the U. S. Department of HEW. Thus, the State of Hawaii will have a single state agency for health planning. Dr. Mills expressed his concerns regarding the implementation of this law and noted that this legislation will have far reaching effects on the medical profession.

ACTION:

It was recommended that a letter be written to the Governor expressing the willingness of the HMA to participate in implementation of PL 93-641.

H. Medical Services: Dr. Moore announced that the new 1976 Worker's Compensation Fee Schedule became effective January 1 and is available in the HMA Offices. The schedule reflects an 8.1 per cent increase in the cost of living index.

OTHER BUSINESS

A. Purchase of Ward Avenue Site: Dr. Dang reported that the building at 320 Ward Avenue was purchased on December 15, 1975 and outlined the terms of the sale. He presented a comprehensive slide presentation on the geographic features of the building, the terms of the sale, the projected use of the HMA's Capital Investment Fund and the operational aspects of the building. These slides will be shown at all county medical society meetings in February and March. There was discussion regarding the future use of the Capital Fund, whether or not the fund should be continued indefinitely, an investigation of HMA's future space needs for projects, and an appeal to the membership to make full payment to the Fund as quickly as possible in order to reduce the building debt.

ACTION:

It was voted to request the President to appoint a long-range planning committee to manage the Capital Fund and the building income and to investigate the future uses and needs of the Fund and report back to the Council.

B. Building Management Committee: An ad hoc committee on Building Management was appointed as follows: Drs. Dang, Sia, and Bell II.

C. Implementation of the Dang Plan (HMA Capital Investment Fund); Letters will be sent to all HMA members asking them to select an option for payment of their contribution to the Dang Plan. The first payments will become due March 31, 1976.

D. AMA Delegation: As of December 31, 1975, active membership in the HMA exceeded 1,000 members entitling the HMA to send two delegates to the AMA House of Delegates and Clinical Session.

ACTION:

It was voted to request Alternate Delegate Herbert Chinn, M.D. to serve as the second delegate for the June 1976 meeting of the AMA.

A motion was made and amended to ask the President to appoint two alternates pro-tem for the June 1976 meeting with approval by the Council. It was voted to refer this matter to the Bylaws Committee for their study and report. It was also voted to instruct the Bylaws Committee to review the Bylaws and provide for the election of two delegates and alternate delegates to be elected in alternate years.

NEW BUSINESS

A. Physician's Action Group: Dr. Roy Kuboyama was asked to serve as the HMA representative to the Physician's Action Group.

B. It was voted to endorse the Institute of Renal Disease program for the fall of 1976.

ADJOURNMENT

The meeting adjourned at 10:00 p.m.

R. VARIAN SLOAN, M. D.,
Secretary



Serum Digoxin

Cardiac glycosides have been used in the treatment of cardiovascular diseases for nearly



200 years, but there are still serious problems in their optimal use. They are the most common cause of adverse drug reactions; toxicity has been reported in as many as 20% of hospitalized patients taking digitalis.[1] The problem of toxicity is compounded by the fact that inadequate dosage may evoke similar symptoms. Some studies have shown that as many as 36% of patients on maintenance doses were underdigitalized.[2]

Before methods of measuring serum digoxin levels were available, cardiac glycosides were given until therapeutic effects occurred or toxic symptoms developed. Therapeutic effect was defined as an improved clinical condition manifested by diuresis and relief of the signs and symptoms of heart failure. Toxic symptoms include loss of appetite, nausea and vomiting, visual disturbances, mental confusion, ventricular premature beats, nodal and ventricular tachycardia, various degrees of heart block, atrial standstill and atrial fibrillation. The difficulty with this method is that the therapeutic dose approaches the toxic dose, the more severe the heart failure.

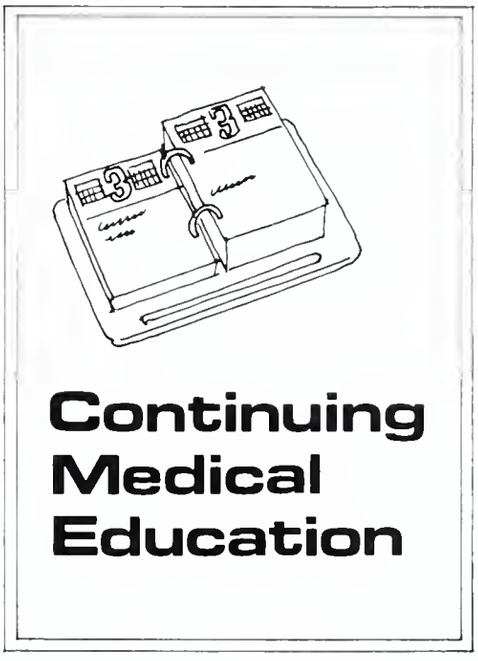
Various studies have shown that there is good correlation between serum and myocardial digoxin concentration after attainment of serum -tissue equilibrium.[3] Therapeutic serum levels of digoxin are 0.8 to 1.6 ng/ml (drug dosage of 0.25 mg) and 0.9 to 2.4 ng/ml (dosage of 0.50 mg). There is an overlap between high therapeutic and toxic levels, but about 90% of nontoxic patients have serum levels below 2.0 ng/ml and 90% of the toxic patients have levels over 2.1 ng/ml. Therapeutic levels for digotoxin range from 3 to 39 ng/ml and toxic levels are from 26 to 43 ng/ml. Because of cross reactivity of the assay methods and the different toxic ranges for digoxin and digitoxin, the physician must be specific about which test is desired.

Interpretation of serum digoxin levels require a knowledge of the absorption curve of the drug. There is a prompt rise of serum levels following oral ingestion, with a peak between 1 to 4 hours, followed by a drop to a plateau in about 5 hours. The effects of a specific dose should therefore be determined about 6 hours after ingestion of the drug. The effects of a constant daily dose should be tested after the first six days, before the morning dose. When a problem involving therapy, such as toxicity or failure to respond to the usual dose, is suspected, the serum level can be determined at any time and subsequent assays will confirm or alter the course of treatment.

In addition to the narrow and frequently overlapping ranges between therapeutic and toxic doses, the patients receiving cardiac glycosides are frequently elderly and have other systemic diseases that may influence the metabolism and excretion of the drugs. Patients with renal disease (BUN over 40mg/dl) may become toxic with average doses. The usual therapeutic dose may be toxic in the presence of hypokalemia, hypomagnesemia, hypercalcemia or acid-base imbalance and hypoxia, especially in acute or chronic lung disease. Hypothyroid patients are very sensitive while hyperthyroids are resistant to cardiac glycosides. Patients with malabsorption also require larger doses. Different brands of digoxin are often not equally bioavailable and there may also be differences within the same brand.[4] These factors make determination of serum levels even more valuable.

REFERENCES

1. Beller, GA et al: Digitalis Intoxication: A prospective clinical study with serum level correlation, *New Eng J Med* 284:989-997, 1971.
2. Henderson RR et al: Serum digoxin levels in cardiac outpatient population: A prospective clinical study, *Circulation* 44 (Suppl. II): 177 (1 page only), 1971.
3. Doherty JE et al: The distribution and concentration of tritiated digoxin in human tissues, *Ann Intern Med* 66:116-124, 1967.
4. Skelly JP Knapp G: Biologic Availability of Digoxin Tablets, Editorial, JAMA 224:243, 1973.



CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division
1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m.

Kaiser Hospital
(Contact CME Dept. for further information)

Kauikeolani Children's Hospital
1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program

Kapiolani Maternity Hospital
1. Grand Rounds, Wednesdays, 7:30-8:30 a.m.
2. Resident Conference, Tuesdays (except 1st), 1:00 p.m.
3. Ob-Gyn Department Meeting, 1st Tuesday, 1:00 p.m.
4. UH Seminars, Wednesdays, 3:30 p.m.
5. Perinatal Conference, Thursdays, 3:30 p.m.
6. Tumor Board, 1st & 3rd Fridays, 1:00 p.m.
7. Oncology Conference, 4th Friday, 1:00 p.m.
8. Visiting Professor Program

Kuakini Hospital

1. Hematology Rounds, Monday, 1:00-2:00 p.m.
2. Gastroenterology, Tuesday, 8:00-9:00 a.m.
3. Oncology Conference, Thursday, 8:00-9:00 a.m.
4. Endocrine Conference, 2nd Wednesday each month, 1:00-2:00 p.m.
5. Medical Statistics, 3rd Tuesday each month, 1:00-2:00 p.m.
6. Renal Conference, Wednesdays, 1:00-2:00 p.m.
7. Kidney Biopsy Conference, Tuesdays, 1:00-2:00 p.m.
8. Visiting Professor Program
9. G.I. Rounds, Tuesdays, 8:00 a.m.
10. Infectious Disease Conference, Thursdays, 1:00 p.m.

St. Francis Hospital

1. Medical Grand Rounds, Tuesdays (4th & 5th), 1:00-2:00 p.m.
2. Surgical Grand Rounds, Fridays (except 4th), 7:30-8:30 a.m.
3. Tumor Conference, Mondays, 7:30-8:30 a.m.
4. Visiting Professor Program
5. Clinical Pathology Topics, Mondays, 10:00-11:00 a.m.
6. Microslide Conferences, Tuesdays, 8:30-9:30 a.m.
7. Bone Marrow Pathology, Tuesdays, 2:00-3:00 p.m.
8. Basic Science Review & Research Conference, Thursdays, 1st & 3rd, 8:00-9:00 a.m.
9. Psychiatric Case Conference, Tuesdays & Fridays, 8:00-9:00 a.m.
10. Psychiatry for the Non-Psychiatrist, Tuesdays, 10:00-11:00 a.m.
11. Psychiatry Teaching Rounds, Thursdays, 9:00-10:00 a.m.
12. Medical Psychiatric Joint Teaching Rounds, Fridays, 11:00-12:00 noon
13. Surgical Mortality & Morbidity Conference, last Friday, 7:30-8:30 a.m.
14. Saturday Teaching Rounds, Saturdays (except 4th), 7:30-8:30 a.m.

Straub Clinic & Hospital

1. Medical Grand Rounds, first Thursday, 7:00 a.m.
2. Surgical Mortality & Morbidity, 4th Thursday, 7:00 a.m.
3. Quarterly Professional Staff Meetings, (Jan., Apr., Aug., Nov.), 4th Monday, 7:30 p.m.

Wahiawa General Hospital

1. Noon Seminars, 2nd Friday & 4th Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:30 p.m. & 2nd Wednesday, 12:30 p.m. of each month in the Mabel Smyth Building. Contact HMA Office as dates are subject to change.

SPECIAL EVENTS

April 14	"The Establishment of Evaluation of CORE Competencies in Adult, Adolescent, and Child Psychiatry—A Study of the American Board of Psychiatry and Neurology" sponsored by the Hawaii Psychiatric Society, at 7:30 p.m. in the Mabel Smyth Bldg. For further information contact Mrs. Arien Grabbe (595-6371).
May 1-8	Management of the Surgical Patient at Mauna Kea Beach Hotel, Kamuela; sponsored by Stanford University School of Medicine; 27 hours credit; for more information, write: Edward Rubeinstein, M.D., Associate Dean, Postgraduate Medical Education, M121, Stanford University Medical Center, Stanford, CA 94305.
May 25	Minicourse on Orthopedics at Wahiawa General Hospital Dining Room, 12:30 luncheon meeting and 6:00 p.m. dinner meeting. Contact Dr. Richard Tesoro for further information. Four hours instruction.
May 13	American Ophthalmological Society, Mauna Kea Beach Hotel. Contact Dr. Robert Hollenhorst, c/o Mayo Clinic, 200 Southwest First Street, Rochester, Minnesota 55901.
June 20-25	South Pacific Commission Cancer Seminar at the Pagoda Hotel, sponsored by the American Cancer Society. Contact: John R. Watson, M.D. or Kay VanSant at 531-1662.
August 9-13	Emerging Medical, Moral, and Legal Concerns sponsored by St. Francis Hospital and the National Kidney Foundation at the Princess Kaiulani Hotel; 18 hours credit; for more information contact Dr. Arnold Siemsen, 948-7433.
October 3-8	VI Asian Pacific Congress of Cardiology at the Sheraton-Waikiki; contact Dr. Morton Berk for further information at 537-2211.
October 18-22	American College of Physicians—Workshop in Internal Medicine; Ilikai Hotel; contact Dr. John Kim for further information at 949-5811.
October 25-29	Hawaii Medical Association Annual Meeting; Ilikai Hotel; contact Bess Chang for further information at 536-7702.

The seminars on "Sexual Counseling: Office Management of Sexual Problems" sponsored by the ACOG and University of Hawaii will be held on the following dates: (20 hrs. credit)

April 19-23	November 22-26
October 18-22	December 20-24

April 11-16 Colposcopy—A Refresher Course, at Lahaina, Maui; 25 hours credit.

For further information, write to: American College of Obstetricians & Gynecologists, Department of Continuing Education, 1.E. Wacker Drive, Suite 2700, Chicago, IL 60601

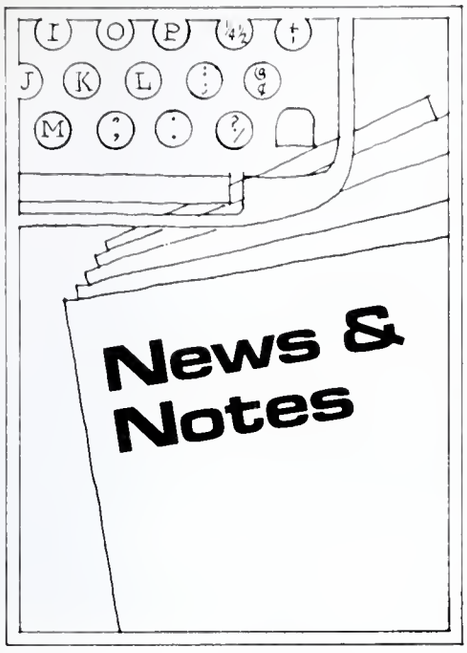
Programs sponsored by the University of Southern California:

April 24-May 1	Chest and G.I. Radiology, at Royal Lahaina Hotel, Maui.
April 24-May 1	Pediatric Review, at Maui Surf, Maui.
April 26-May 1	Diagnostic and Therapeutic Skills, at Mauna Kea Beach Hotel, Kamuela, HI.
April 26-May 1	Emergency Medicine, at Kauai Surf, Kauai.
May 23-30	Nephrology, at Maui Surf Hotel, Maui.
June 13-20	Orthopedic Review, at Mauna Kea Beach Hotel, Kamuela.

For further information, contact: Phil R. Manning, M.D., Associate Dean, Postgraduate Division. USC School of Medicine, 2025 Zonal Ave., Los Angeles, CA 90033.

OUT OF STATE

For information on any out-of-state programs or courses, refer to August 11, 1975 Supplement to JAMA or call the HMA Office.



HENRY N. YOKOYAMA, M.D.

Professional Moves

Our friend the oriental soothsayer predicts that the Year of the Dragon will bring good fortune, that the Dragon will wipe out evil influences with one flaming breath, and bring happiness to everyone including our own beleagured species, the *Homo Sapiens Medicus* . . . The following professional moves occurred in March . . . In Honolulu, internist **Richard Inamine** relocated to 2658 S. King St., GP **Paul Y. K. Lin** associated with **Thomas Cahill** in Aiea at 99-185 Moanalua Rd.; pathologist **Vera Hlaing** and radiologist **Chung Ta Hsin** joined the Hawaii Permanente group . . . On Maui, OB man **William Gintling** joined the Maui Medical Group and on Hawaii, internist-gastroenterologist **Myron Lezak** joined the Hilo Medical Group.

On the Health Department front, **James Drorbaugh** who was director of the Maternal-Infant Health Project at Harvard University Children's Hospital-Medical Center and project physician at the Boston Hospital for Women will replace **Merle McPherson** as physician of the Maternal and Child Health Branch. Merle became chief of the Children's Health Services Division. **Brooks Griffith** who headed the State Health Department's Mental Health Services division on Kauai was transferred to Kona as a staff psychiatrist.

BULLETIN

2nd Annual KCH fundraiser at the Hilkai Pacific Ballroom on May 8. . . Tickets $25. . . Featuring Alan and Julie Grier. . . General Chairman **Ann Barbara Yee** and Program Chairman **Ed Kagihara** remind us that Alan and Julie have written a special song for KCH entitled, "Because You're Young, Because You're You" and that the program will also include Hilo Hattie, the Waimanalo Keiki Chorus, the Floating Ribs and others, dancing to The Torchers and a special auction. . . Good cause and deductible. . . Lots of entertainment. . .

Our golfing pathologists **Tom Kobara** and **Art Salcedo** announce that the Hawaii Society of Pathologists' meeting on July 23 and 24 (Friday and Saturday) on Kauai will also include a tennis tournament (to appease our tennis playing pathologists like **Herb Uemura** et al) as well as the 27 hole Florida scramble. All physicians are welcome to attend the sessions. . . Prizes galore. . .

Ron Pion is appearing in a TV spot, "Health Forecast and Report" on KITV with Don Rockwell, 2 or 3 times a week. . . Ron asks local physicians to send in health hints on health care, prevention, etc.. . . so he can be a "Spokesperson" for local physicians. . . The health tid bits can be sent to: "Ron Pion; "Health Forecast & Report", c/o HMA Office.

Life in These Parts

Poor **Terry Rogers,** our friendly med school dean, always harried by financial problems, is now beset by rising malpractice insurance rates. Terry recently told the House of Higher Education Committee that the premiums have risen from $118,869 in 1974-75, $314,705 in 1975-76 to a ridiculous $515,000 for 1976-77, even after trimming coverage from $10 million to $1 million. . . "The medical school operates in the real world and we must have actual cash dollars to pay the insurance company on July 1 or the school cannot continue to operate. . . "

Hematologist **Bob Jim** reported on "Hemoglobin G Waimanalo" at a regional meeting of the American College of Physicians. Bob first found the new abnormal hemoglobin in a 73 year old Filipino man living in Waimanalo and in his family. . . The abnormality is in the 64th position of the alpha hemoglobin chain with asparagine replacing aspartic acid. . .

Kona again makes news with the headline: "Kona Doctors Scream 'Foul'". . . The doctors were protesting the selection of an unqualified administrator for the new $5 million 83-bed Kona Hospital by Big Island politicians. . . Then **George Yuen,** State Health Director, stepped into the picture and reassured Kona Hospital chief of staff **Frank Ferren** and others that the most qualified person will be selected. . . Frank acquiesced and commented, "All we want is the most qualified candidate."

Tim Kuberski, infectious disease specialist with the Pacific Research Section of the National Institutes of Health, reported at the regional meeting of the American College of Physicians that NGU (nongonococcal urethritis) is the most common sexually transmitted disease. . . Tim feels that tetracyclines work best with NGU which appears to be caused by several organisms and presents symptoms milder than those of GC. NGU often relapses 4 or 5 weeks after the initial episode. . .

In late March, Honolulu physicians and health officials were as perplexed as officials of the World Health Organization and did not feel that President Ford's plan for a $135 million mass immunization plan for Swine flu was justified. . . **Gordon Wallace** of the Pacific Research Section, NIH of Allergy and Infectious Diseases and who has been studying the natural history of swine influenza, feels that it was circumstantial evidence that pinned the swine virus to the influenza pandemic of 1918. Gordon says, "It's well and good to develop a vaccine against the swine strain, but to go ahead on the basis of available information and vaccinate the whole country seems unjustified—from the standpoint of cost and time involved." State epidemiologist **Ned Wiebenga** also feels that the idea of mass influenza immunization will be controversial and that not all physicians will agree that everyone ought to be inoculated.

A DSSH survey on the Big Island revealed that 17 of the 39 physicians responding were unwilling to take additional welfare cases. Twenty-five said compensation was inadequate, 11 cited slow compensation and 16 said they had difficulty treating such patients. . .

Medic Data, Inc., a Hawaii corporation based in Kaneohe, will provide subscribers with wallet sized cards incorporating microfilmed information about their medical history, allergies, special conditions and blood types for a one time fee of $4.95 plus tax. . . The subscriber also receives stickers for his auto and his driver's license. Children will be able to wear their microfilmed histories at a lower price on a neck chain. . .

Among the 17 men and women crew of the *Hokule'a*, the large ocean-going canoe of the Polynesian Voyaging Society which will attempt to sail to Tahiti, will be a **David Lewis,** physician and an eminent scholar in Polynesian navigation. David will conduct experiments in navigation with Piailug, a micronesian navigator. . . David feels that the Polynesian and Micronesian navigation systems have a common Pacific-wide navigation tradition and that while long distance navigational skills have disappeared from Polynesia because of modernization, they survive in isolated parts of Micronesia. . . He and others have investigated and revived the traditional navigation system and now the navigators of Satawal and Puluwat Atolls make annual round trip voyages of 1300 miles to Saipan in sleek outrigger canoes only 26 feet long. . .

Since the institution of Tel-Med (3 to 5 minute tapes on everything from hypertension to organ transplants), the

biggest demand has been for tapes that relate to sex. **Rowlin Lichter** reports, "When we run an ad, calls come in up to 500 a day. Between times, they drop to about 100." The most requested tapes have been "Male Sex Response" and "Marijuana" followed by "Methods of Birth Control," "Leukemia," "Female Sex Response" and "Labor Induction." The Tel-Med number is 521-0711 and is answered Monday through Friday from noon to 8 pm. There are 180 tapes available and more to come. . .

A $100,000 lawsuit against Olokele Sugar Co. in Kauai was settled out of court. The suit was filed by a woman who, while driving, was overcome by smoke from a burning canefield and rammed into a ditch sustaining injuries to her neck. "Much of the testimony during the trial came from physicians disagreeing over the cause of Mrs. Fujimoto's pain. **Dr. Thomas Grollman** said there 'was no question' the pain arose from the injuries, while Honolulu physician **Herbert Luke** said the pain may be emotionally caused."

The AMIS (Asprin Myocardial Infarction Study) needs Oahu residents aged 30 to 70 who have had at least one heart attack within the past 5 years. **Judson McNamara,** principal investigator, assisted by **Sam Gresham** and **Alfred Morris** are afraid that if the quota of 120 is not met by May 1, Hawaii may be dropped from the 3 year study project funded by the National Heart and Lung Institute. . . Enrolled is cardiologist **Mort Berk** (who had a moderate attack 3 years ago at age 59) who says, "The study opens up a whole new vista of possibilities to prevent heart attacks. . . I feel strongly that participants can help their fellow men and themselves as well. . .

Tom Thorson's Corner

An old man walking down the street met a lil' tyke sitting on the curb and sobbing bitterly. . . "Sonny, Why are you crying?" "I can't do what the big boys do." The old man therewith sat on the curb next to the boy and started to cry too!

One beautiful Sunday morning, Jesus was walking along when he found a man sitting on the curb sobbing sadly. . . "Why are you crying?" "I'm blind. . . I can't see." Thereupon Jesus placed his hand on the blind man's eyelids. . . The eyes popped open in wonderment and the man ran down the street joyously proclaiming, "I can see! I can see!" Next Jesus came upon another man crying on the curb. . . "Why are you crying on such a beautiful day?" "I'm deaf. . . I can't hear." So Jesus touched the man's ears and the man could suddenly hear the birds chirping and all the sounds of a happy world. . . He jumped up and down yelling, "I can hear! I can hear!" Further along, Jesus came upon another man with a cane sitting on the curb and crying. . . "Why are you crying?" "I am crippled. . . I can't walk." Jesus placed his hand on the crippled legs which quickly became whole. The man threw away his crutches and ran down the street. . . "I can run! I can run!" Finally Jesus came upon a morose man crying miserably on the curb. . . "What is your trouble?" "I'm Portuguese!" Whereupon Jesus sat down on the curb next to the man and started to cry too!

Jim and May went to a masquerade party in the country dressed as a cow. Jim had the front half and May the rear. Enroute home, their car stalled in a blinding rain storm. . . Across the pasture from the road, they could see the lights of a farm house. They donned the cow outfit to keep dry, and headed across the pasture. They suddenly encountered a snorting bull. . . Asked May, "What shall we do?" Jim replied, "I'm going to pretend I'm eating grass, but honey! you'd better brace your feet!"

Sportsmen

After the Hawaiian Open, **Dick Ho, Catalino Cachero** and **Henry Yim** played with Hale Irwin at Mid Pac one Wednesday afternoon. At the 19th Hole, Dick, Catalino and Henry were getting advice on how to improve their games. Dick was told to slow down his swing, Catalino was told to reach out more when addressing the ball but Hale offered no advice for Henry. Henry, anxiously pressed the issue: "How about my swing?" Hale looked at Henry with serious mien and commented forthrightly, "If I were you, I'd go home, clean and oil my clubs and store them in a closet." (As retold by **Quint Uy, Ben Tom,** and **Francis Oda** and confirmed by Henry Yim himself)

Belated results of the St. Francis Golf Tournament at Mid Pac CC on Sept. 16:

Low Gross: **Dick Ho** 74-7-67
Low Net: **Al Paraz** 80-15-65
2nd low net: **E. Orinion** 95-25-67
3rd low net: **Quint Uy** and **Dick Mitsunaga** with 68's
Hi Gross: **Francis Au** 119
Hi Net: **Paul Tamura** 90.

Mid Pac Thursday Club:

September Trophy: **Ike Nadamoto**
October Trophy: **Mike Okihiro**
President's Trophy: Mike Okihiro with net 66

1975 HMA Annual Tennis Tournament (14 doubles teams entered)

Winners: **Yutaka Yoshida** and **Leabert Fernendez**
Runners-up: **Ben Tom** and **Charley Ching**
Consolation Flight winners: **Niall Scully** and **David Andrews**
Runners-up: **Victor Dizon** and **James Bennett**

Teams entered: Alex Roth and Shig Horio; Worldster Lee and Ernest Lee; Gene Doo and Cal Sia; Carl Lum and Allan Leong; Niall Scully and David Andrews; Jeffrey Sol and Norberto Baysa; Virgil Jobe and Philip McNamee; Larry Gordon and Donald Jones; Dennis Maehara and Hiro Tottori; Victor Dizon and James Bennett; Bal Raj Mehta and Wilfred Tashima; Sidney Wong and Tad Iwanuma; Yutaka Yoshida and Leabert Fernendez; and Ben Tom and Charley Ching.

Commentary: Yosh and Leabert whose combined ages total 125 appear to improve with age and show no signs of ever slowing down . . . And may they never slow down . . .

Tom Leineweber's Repertoire . . .

"Getting things done around here is like mating elephants!

- It's done at a high level.
- It's accomplished with a great deal of roaring and screaming.
- It takes two years to produce results."

"If you can't dazzle them with brilliance, snow 'em under with B.S."

Elected, Appointed, Honored

Maui pediatrician **John Briley** was elected president of the Maui Association for Children with Learning Disabilities (MACLD) . . . **John Newman** of the Hilo Medical Group was named a diplomat of the American Board of Family Practice . . . **Glenn Stahl** of the Windward Medical Center was elected chairman of the Windward Unit, American Cancer Society . . . **Joseph Tsai** is a new member of the Kaneohe Business Group . . . **Russell Carlson, Samuel Gresham, William Montgomery** and **Patrick Okamura** attended the 3 day course in advanced cardiac life support at . .the American Heart Association National Center in Dallas . . . The Joint Commission on Accreditation of Hospitals (JCAH) has accredited Castle Memorial Hospital for 1976-77 . . . The CME program at Kuakini Hospital has been accredited by the American Medical Association . . . Queen's Hospital was awarded a 3 year $251,000 grant from the National Cancer Institute to establish a comprehensive cancer care project . . . **Noboru Oishi** is principal investigator for the project and **Elmer Johnson** medical consultant . . .

Why shouldn't a Trust Fund benefit you while you're living?



Now it can. We call it a Living Trust. It's created and put to work during your lifetime.

A revocable Living Trust from First Hawaiian Bank helps you minimize the problems and details of managing properties and other assets. And, of course, you retain full ownership and control.

It's a very personal document, tailored to your circumstances and the desires you have for providing for your family. For a more detailed account of how the Living Trust can benefit you, call Joe Battista, Ken Nakamura or Herb Loomis in our Trust Division at 525-7051.

First Hawaiian Bank
Hawaii's only full service trust bank.

MEMBER FDIC

Miscellany

An elderly woman saw a plastic surgeon for a face lift . . . Surgeon after examining her: "Madam, you don't want a plastic surgeon . . . You want an exorcist . . . " (Our favorite humorist **Claude Caver**)

The Marquis de Sade was such a prolific writer of orgy stories because he did most of his writing while waiting for one of his rare erections . . . (Our Oklahoman oncologist friend, **Paul Condit**)

"You know how to make a Portuguese completely frustrated? . . . Put him in a round room and tell him to pee in a corner . . . " (Says **Tom Thorson**)

Visiting Physicians

In February, Clark Millikan, professor of neurology at Mayo University, was in town. Clark, a thin, medium statured, gravel voiced, warm, likeable intellectual with short cropped grey hair and gold rimmed glasses gave relaxed, anecdotal and delightful lectures on TIA's and CVA's:

re, Ddx CVA's: "TIA's do not occur before intercerebral hemorrhage . . . " "Think infarct rather than hemorrhage if at night or early morning" . . . "The exception is subarachnoid hemorrhage a/c intercourse . . . "

re, Rx of TIA's: "We've been unenthusiastic about administering CO2" . . . "The position of Aspirin in TIA's is up for grabs . . . "

re, Cholesterol emboli: "Cholesterol emboli are flat and when you press on the eye, they wink back at you . . . "

Grant Stemmerman Says

The Japanese in Hawaii have a 4 to 5 times greater incidence of CA of the biliary tree than other groups . . . Most occur after age 60 . . . Over half of the CA of the common duct occur after age 70 . . . CA of the ampula and the GB occur in women and younger groups . . . 10% of acute suppurative cholecystitis have CA either in the gall bladder or the duct . . . Treatment should be conservative with a point of view of comfort . . .

Hors De Combat

Excerpt from Dave Donnelly's column: "BRILLIANT CASTING: Dancer Jed McKuen pulled a leg muscle during an early section of 'Swan Lake' at the Concert Hall on Sunday afternoon, but was able to continue, thanks to the King. The King in the ballet, fortunately for McKuen, was played by **Dr. Robert Lindberg,** an orthopedic surgeon at Straub Clinic. Dr. Lindberg worked on the leg, taped it and packed it in ice and thanks to his quick effort McKuen was able to complete the performance."

Emmett Aluli, Hawaiian activist and medical resident at Queen's, was charged with trespassing on a U.S. military reserve by the U.S. Government and released on a $500 signature bond pending his trial on April 14. Emmett is one of the men spearheading attempts to return Kahoolawe to the Hawaiian people . . .

An enlightening article by Sanford Zalburg reveals that lawyers are also liable for malpractice suits . . . An insurance agent said, "Up till now there have not been a whole lot of claims against lawyers . . . They are just beginning to bite each other . . . " In 1974, there were 22 malpractice suits, 21 against doctors and hospitals and 1 against an attorney. In 1975, out of 17 malpractice suits, 2 were against attorneys. A study done 4 years ago showed that out of 410 Hawaii attorneys queried, 191 replied they carried malpractice insurance and 93 replied they did not, viz a ratio of 2 to 1 . . . And there is no statute of limitations in malpractice suits against lawyers . . . Also, lawyers seldom take out less than $1 million worth of coverage . . . And the rates depend on the lawyer and what he specializes in . . . One lawyer invented the theorem, "Availability of insurance increases the incidence of suits . . . " (The old adage: "Know thine enemy")

In mid March, the House passed its malpractice bill to head off a medical malpractice insurance crisis in Hawaii. Only GOP Rep. Ike Sutton voted against it on the grounds that there was no need . . . Ike objected saying, "We have hog-tied the doctors and put them under discipline for sins they have not committed."

The Senate malpractice bill passed at the end of March; however, it had been emasculated by the lawyer politicians . . . The Senate bill: does not require attorneys to report information to the insurance commissioner while the insurance companies and the medical community are so required . . . Allows the Board of Medical Examiners to develop minimum standards for 'informed consent' . . . Requires all doctors and hospitals to participate in the patients' compensation fund, the intent of which is to cover awards in excess of $100,000 . . . Both Senate and House bills permit contingency fees of 33⅓% if a suit is settled prior to trial and of 40% after filing a "statement of readiness" (Whereas the State administration wanted attorney's fees limited to 33⅓% of the first $50,000, 20% of the next $50,000 and 10% of anything over $100,000.

Miscellany

A boy was told by his mother to put up a sign warning neighborhood kids to stay away from a pile of lumber stacked in their yard. When she went out to check the sign, she was mortified for it read: "It is dangerous to play with old broads." (Our former HMA receptionist)

Tom told his doctor that he was having an affair, and that his conscience was troubling him . . . "I suppose you want something to strengthen your will power?" asked the doctor . . . "No," said Tom, "I need something to weaken my conscience." (Submitted by the same receptionist)

A couple had a disagreement and were not speaking to each other . . . Before going to bed, he handed her a note: "Call me at six in the morning." He got up after 8 and as he was dressing hurriedly, he noticed a note saying: "It's six. Get up you imbecile!" (Anonymous)

"What do they call a colored astronaut?" "Give up." "Color moon guy." (Anonymous)

"Fluckey" by Tom Thorson

The wife went to visit her mother and the husband was left at home alone. He decided to take advantage of the opportunity, so he picked up a little floozie in a bar and had himself a fling. Later the nagging fear of VD began to bother him and he visited a doctor other than his family physician. The doctor examined him and assured him that he had a "fluckey." Having never heard of "fluckey," he began to worry again . . . He finally saw his own doctor, explained what happened and asked him what a "fluckey" was. The family doctor had never heard of "fluckey" either and called the doctor who said, "I simply told him he got off lucky."



What do you do if you're a property owner and don't have the time to manage it professionally?



Talk to Dick Hagstrom.

Dick Hagstrom, an expert in property management with more than 15 years of experience, is one of the professionals in Hawaiian Trust's Real Estate Department. His property management responsibilities include office and retail buildings, apartment complexes, warehouses, subdivisions and agricultural lands, among other properties. As a director of the Building Owners and Managers Association, he proves he knows what goes into property management.

Although his Hawaiian Trust activities often take him to the Neighbor Islands, Dick still finds time for studying historic sites within the downtown Honolulu area in conjunction with the Downtown Improvement Association.

If you suddenly find yourself a property owner, or if you planned it that way, and don't have the time or the experience to manage it, Dick Hagstrom can. He and the Real Estate Department of Hawaiian Trust can do everything from an economic study to determine the potential of your property, to collecting rent and getting the roof fixed.

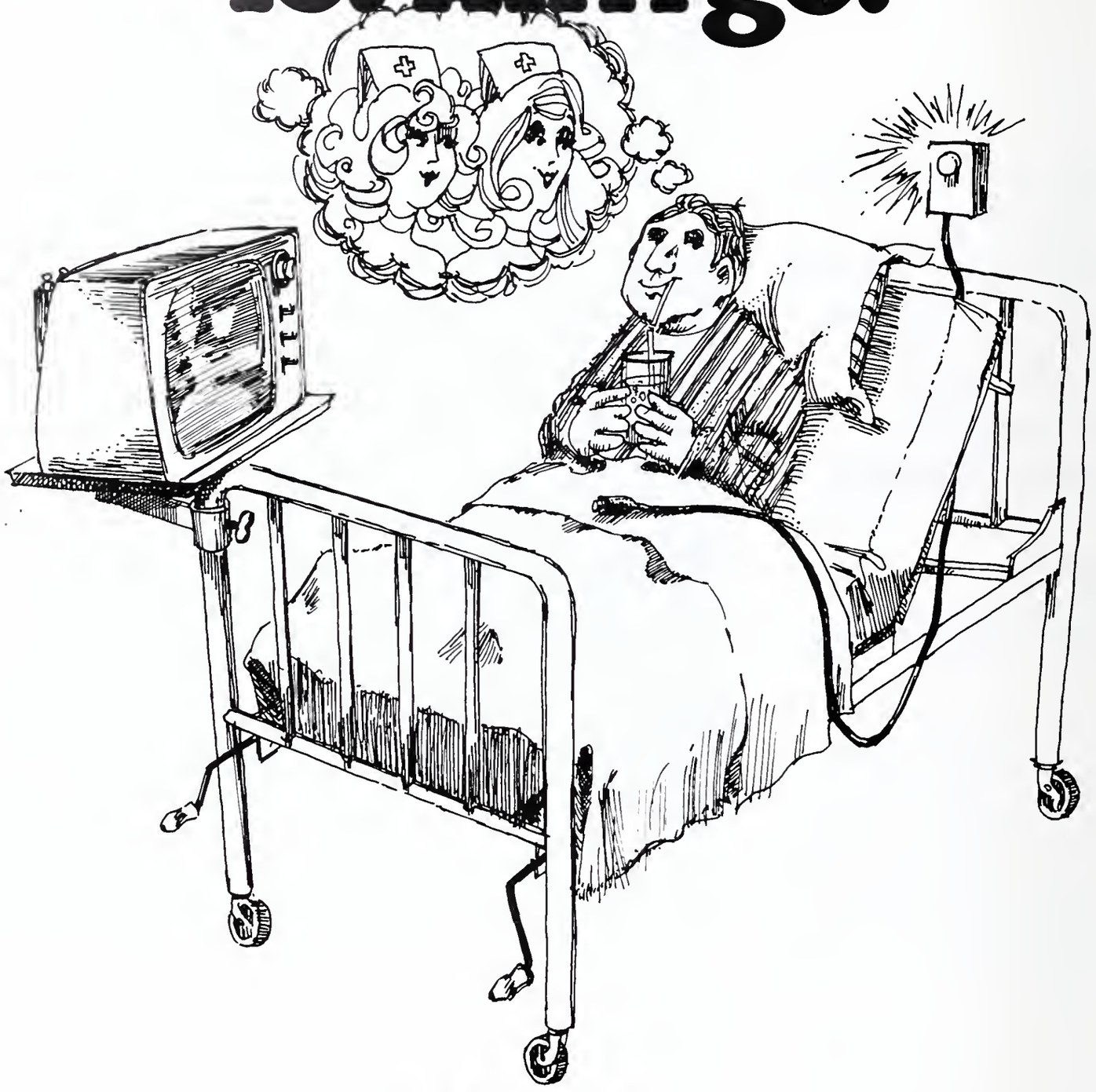
Rely on the expertise gained from dealing with diverse properties on a day-to-day basis, and benefit from the extent and depth of Hawaiian Trust's Real Estate Department. Give Dick Hagstrom a call at 525-8511. He'll manage the rest.

Trust Hawaiian to make it easy.

Hawaiian Trust Company, Ltd.

Financial Plaza of the Pacific, Honolulu, Hawaii 96813
In Wailuku: Wailuku Town House
In Hilo: Kaiko'o Mall

Before he hollers, let him go.



Spare him the discomfort of an extra bundle of hospital bills.

When it's time to discharge a patient, remind him that HMSA can still cover therapy and diagnostic work on an out-patient basis.

It's less expensive, and another way doctors and HMSA can help the people of Hawaii hold down the cost of their medical care.

HMSA®

Hawaii Medical Service Association

Hawaii Academy of Family Physicians' Newsletter

J. L. Frederick Reppun, M.D.

ABFP—Five of our members were certified by the American Board of Family Practice the result of passing the examinations last October 1975. They are **Tom Cahill, Ron Hattis, David Livingston, John Newman,** and **Marc Schlachter. CONGRATULATIONS!**

Hospital Medical/Dental Staffs please take notice: These physicians are CERTIFIED in a specialty!

NEWS OF MEMBERS—Kevin Kunz, UHSM '78 made the newspapers by testifying at the legislature. **Patrick Lowrey** is now a Resident under the UH School of Public Health; what that means is a little obscure, Pat, and we hope you will elucidate. **Mark Wentworth** has had his membership classification changed from Associate to Active. **George Tyau** is now a Life member. **Howard Liljiestrand** has announced his retirement. He is rather too young, don't you think, and hardly looks the part of a senior citizen! **Glenn Stahl** of Kailua, Oahu, and Kaneohe (where he lives) has been appointed chairman of the Public Education Committee of the Windward Unit, American Cancer Society. **Mary Glover** was reported *hors de combat* for a while, succumbing to the enemy: Those who wield the knife. **Doug Doyle** has changed his membership category from Inactive to Life.

QUEEN's MEDICAL CENTER—has announced that our Dean-of-Members **Varian Sloan** has been appointed Chief of the Department of General Practice, succeeding long-time chief Jim Marnie MD. "He's never too old to work", quoted Erna, his spouse. It's great news to the faithful — to have a real Family Physician head the department of **THE** hospital of Hawaii. Varian thus becomes a member of the all-powerful Medical Advisory Committee to the Board of Trustees. Varian is also the perennial secretary of the Hawaii Medical Association.

THE BIG KAHUNA—It was Roger's visit to the Hawaiian Islands last December that set the stage for him being elevated to the class of Alii of Hawaii. Those of you who will be attending the AAFP State Officers Conference in Kansas City this month will note that the Game Plan for the Festivities at the Administrative Workshop on 23 April has our national Executive Director Roger Tusken listed as "The Big Kahuna". Someone must have given our good Roger a degree by mail order!

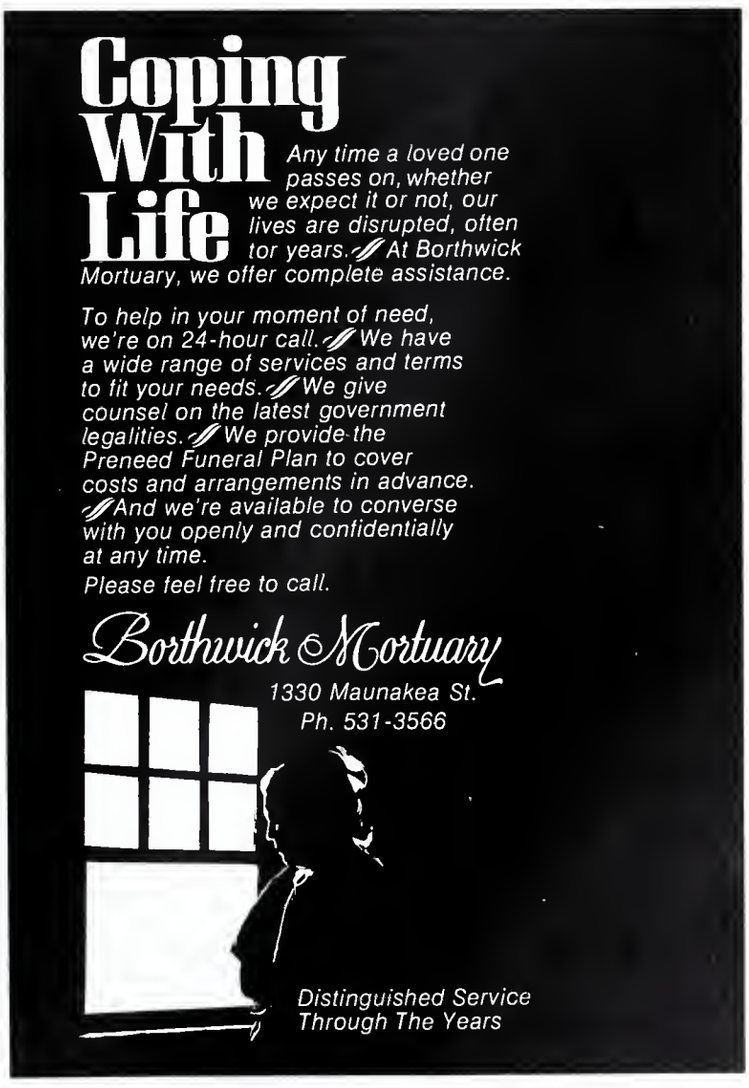
FAMILY MEDICINE REFRESHER CORRESPONDENCE COURSE 100—put on by the Georgia Academy of Family Physicians again, has an application deadline of 23 April. Those of you in the styx should derive considerable category P credit by subscribing. All members have received a mailing on this.

MINUTES-IN-BRIEF—of the Council meeting of 4 March: 22 members have been recertified as of 31 Dec 75 for another 3 years membership. Six still need to turn in their credit hours; the deadline this year is 30 April.

U.S. TREASURY— reports we are in debt to the amount of only $589,967,000,000.00.

Our "Angels"

	Page
Bio-Science Laboratories	
Pathology Associates	107
Borthwick Mortuary	125
First Hawaiian Bank	121
Hawaii Bancorporation, Inc.	
Bancorp Leasing	130
Hawaii Medical Service Association	124
Hawaiian Trust Company, Ltd.	123
Eli Lilly and Company	
Kefzol	108
McNeil Laboratories, Inc.	
Tylenol	106
Lydia O'Leary	
Covermark	116
Pharmaceutical Manufacturers Association	104, 105
PUO International, Inc.	
Saffola	129
Roche Laboratories	
Dalmane	126, 127, 128
Valium	100, 101
Westwood Pharmaceuticals, Inc.	
Presun	102



Effectiveness across the spectrum of most common forms of insomnia

Awake too long, awake too often, awake too early...

These are the most common forms of insomnia, and may occur singly or in any combination. The night of troubled sleep depicted here comprises all three types. As the night progresses from left to right, each sleep stage is identifiable by its own shade of gray. Blue represents "Awake."

As you can see, this hypothetical "patient" takes well over an hour to fall asleep, awakens several times during the middle of the night and awakens too early in the morning.

Sleep Stages

- Awake
- REM
- Stage 1
- Stage 2
- Stage 3
- Stage 4



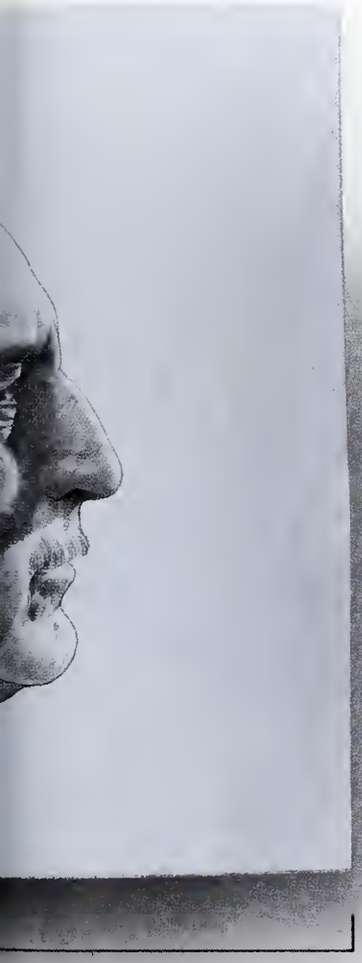
The insomnias most often occurring in young and older adults

For patients with trouble falling asleep (common in young adult insomnia patients), Dalmane (flurazepam HCl) 30 mg provides sleep within 17 minutes, on average. For those with trouble staying asleep or sleeping long enough (common in those over 50), Dalmane offers increased total sleep time with fewer nocturnal awakenings. These clinical results were demonstrated in studies conducted in four geographically separated sleep research laboratories[1-4]

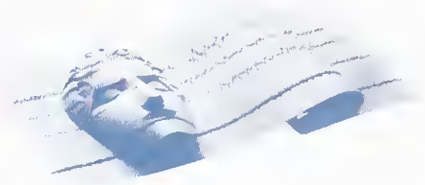
The relative safety of Dalmane (flurazepam HCl) is well documented

Dalmane (flurazepam HCl) is relatively safe and well tolerated; morning "hang-over" has been infrequent. The usual adult dosage is 30 mg; in elderly or debilitated patients, limit initial dosage to 15 mg to preclude over-sedation, dizziness or ataxia. Caution patients about possible combined effects with alcohol and other CNS depressants.

Broad-spectrum medication for the most common forms of insomnia



Awake too early



Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.*— usual adult dosage
(15 mg may suffice in some patients).
One 15-mg capsule *h.s.*— initial dosage for elderly or debilitated patients.

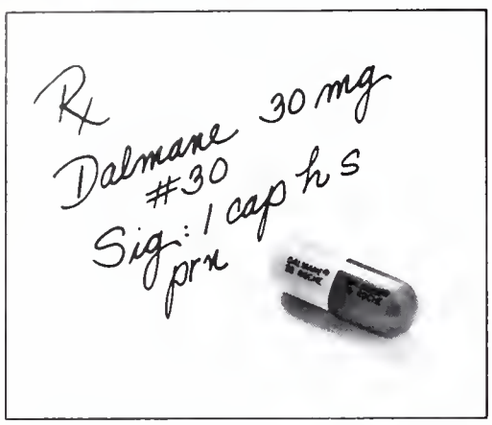
- ☐ induces sleep rapidly
- ☐ reduces nighttime awakenings
- ☐ lengthens total sleep time

ROCHE

Please see following page for a summary of complete product information.

Broad-spectrum medication for the most common forms of insomnia

Dalmane®
(flurazepam HCl) ℞ IV



Objectively proved in the sleep research laboratory, Dalmane

- induces sleep within 17 minutes, on average
- reduces nighttime awakenings
- provides 7 to 8 hours sleep, on average, without repeating dosage

Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

REFERENCES:

1. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
2. Frost JD Jr: A system for automatically analyzing sleep. Scientific exhibit at the 24th Clinical Convention of the American Medical Association, Boston, Nov 29-Dec 2, 1970; and at the 42nd annual scientific meeting of the Aerospace Medical Association, Houston, Apr 26-29, 1971
3. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
4. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ



ROCHE

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

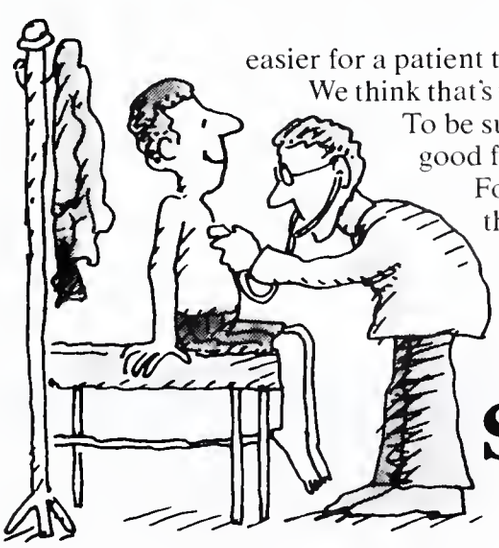
Saffola® is higher in polyunsaturates than Fleischmann's, Imperial or Mazola.



Shouldn't that difference make a difference in what you recommend?

Your patients on modified fat diets can't do better than Saffola. Of the leading margarines, Saffola is highest in polyunsaturates. And no other margarine is lower than Saffola in saturated fats. Because Saffola contains safflower oil—one of nature's most perfect foods. Safflower oil is higher in polyunsaturates than any vegetable oil, including corn oil. But to your patients, Saffola's good taste is just as important as Saffola's nutrition. The flavor makes it easier for a patient to follow a low cholesterol diet.

We think that's why Saffola is worth recommending. To be sure your patients are eating what's good for them, and enjoying it.

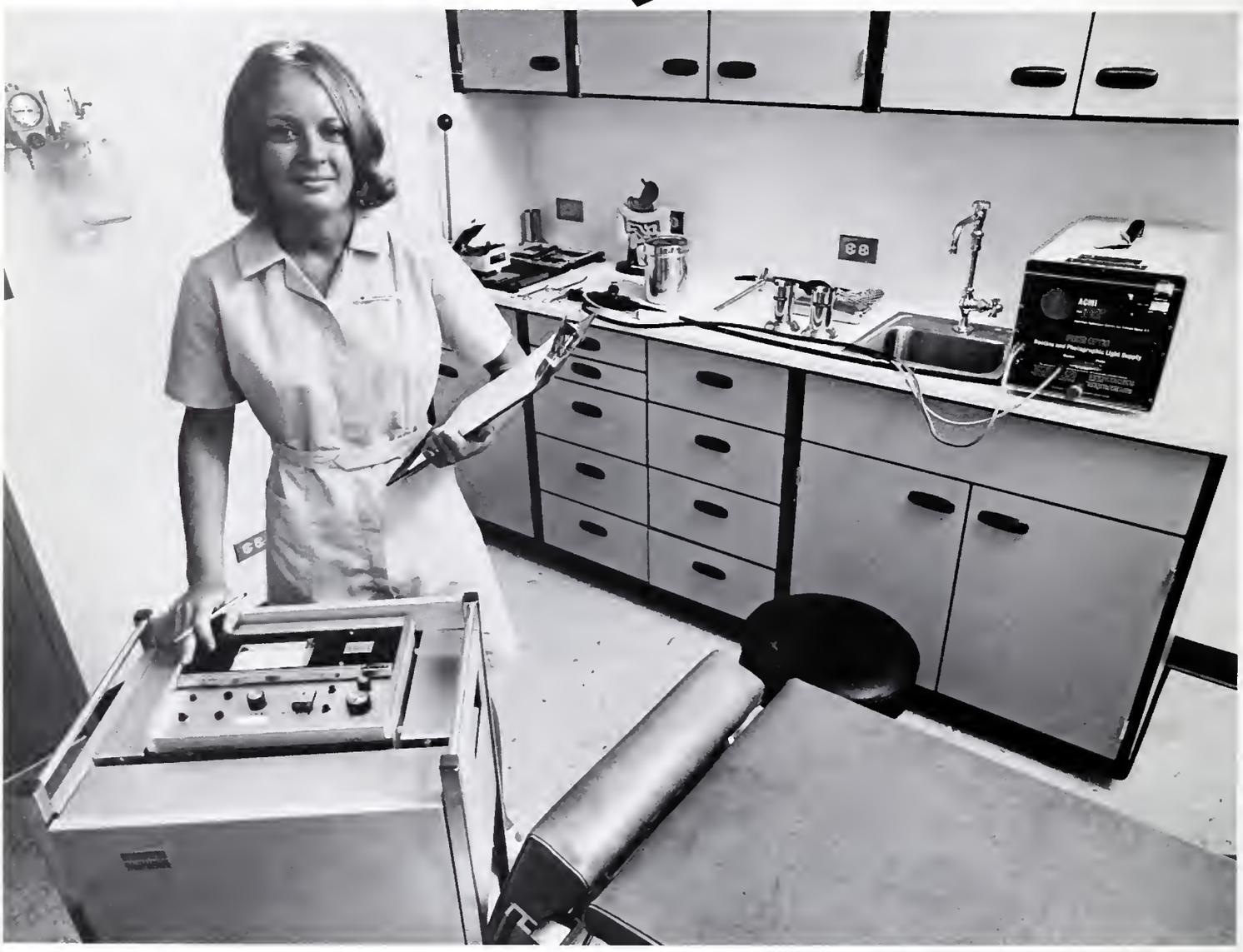


For comparative information about the nutritional benefits of Saffola, write Consumer Products Division, PVO International Inc., World Trade Center, San Francisco, 94111.

Saffola



WHY LEASE MEDICAL EQUIPMENT?



It may be just what the doctor should order. Take a moment and look into it.

Why lease? Well, it has to do with money. Your money. We're Bancorp Leasing, and we're an affiliate of Bank of Hawaii. Together, we know a lot about how to make your money work for you. When you lease your medical equipment, you've got your hard-earned money available for other more pleasant or profitable investments. And there's no cash outlay either. Leasing is also a tax deductible expense. Leasing through us leaves you and your staff free of the paper work involved in equipment acquisitions. It's our worry.

Give us a call at 537-8810. If you like, we can make an appointment to come out and see you. There's no obligation. Except our obligation to help you get as much out of your capital as possible.

BANCORP LEASING

A subsidiary of Hawaii Bancorporation, Inc.
and an affiliate of Bank of Hawaii

Hawaii Bancorporation Leasing, Inc. / P. O. Box 2900, Honolulu, Hawaii 96846 / Phone 537-8810

MAY, 1976
VOL. 35, NO. 5

HAWAII MEDICAL JOURNAL

CONTENTS

Campylobacterosis 139
Ray T. Huffman, M.D.

Announcement 135

Book Reviews 150

Clinical Pathologist's Easy Chair 151

Continuing Medical Education 145

Editorials 144

Hawaii Academy of Family Physicians' Newsletter 150

HMA Council Meeting 146

HMA Newsletter 143

New Members 151

News & Notes 152

The Library
Acquisitions Division SP
University of California, San
Francisco
San Francisco California 94143

LIBRARY
U.C. SAN FRANCISCO
JUN 23 1976

Both often



Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

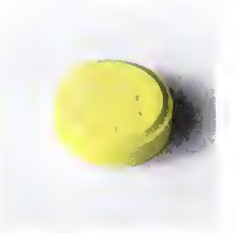
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequen and/or severity of grand mal seizures m require increased dosage of standard an convulsant medication; abrupt withdraw may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous in gestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) hav occurred following abrupt discontinuanc (convulsions, tremor, abdominal and mu cle cramps, vomiting and sweating). Kee addiction-prone individuals under carefu

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium®
(diazepam) Ⓘⓥ

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

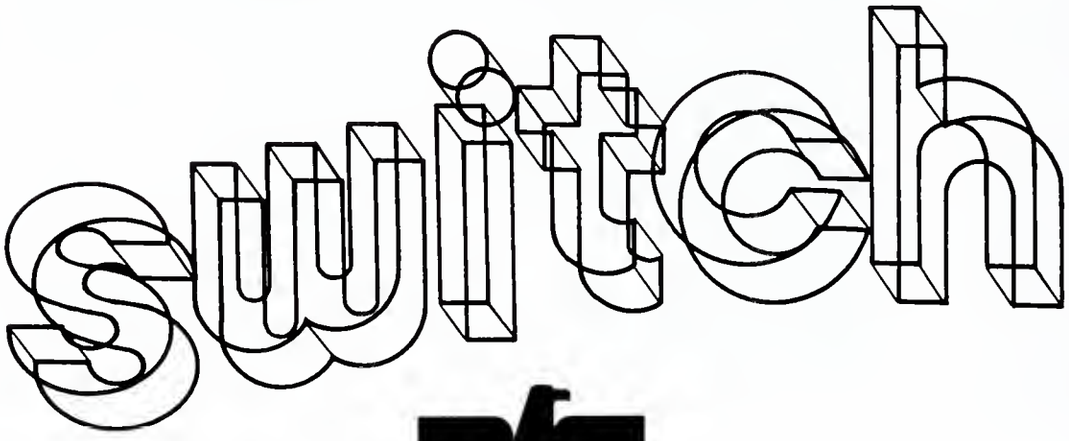
ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

vast cash.

Right now, we have considerable mortgage money available for owner-occupied, single-family homes. Up to $200,000 — far above normal maximums — with good terms and very competitive rates.

Also, we can make a mortgage commitment in a fast 48 hours, subject to appraisal of the property you're interested in. Call the Mortgage Department at 525-7888 or your nearest branch and schedule an appointment. We're aggressive lenders with a lot of cash to lend. And that's why so many home buyers are switching to American Security Bank. Even if they don't bank with us now.



to

American Security Bank
MORTGAGE DIVISION

EQUAL HOUSING LENDER

HAWAII MEDICAL JOURNAL

Published Monthly by the
HAWAII MEDICAL ASSOCIATION
(Incorporated in 1856 under the Monarchy)
510 S. Beretania St., Honolulu, Hawaii 96813

EDITORS

Editor, HARRY L. ARNOLD, JR., M.D.
News Editor, HENRY N. YOKOYAMA, M.D.
Assistant Editor, DORIS R. JASINSKI, M.D., M.P.H.
Contributing Editor, ROBERT H. MOSER, M.D.
Contributing Editor, J.I. FREDERICK REPPUN, M.D.
Book Review Editor, WINFRED Y. LEE, M.D.
Executive Editor, PAUL STEWARD

OFFICERS

President, WILLIAM W.L. DANG, M.D.
President-Elect, CALVIN C.J. SIA, M.D.
Past President, WINFRED Y. LEE, M.D.
Secretary, R. VARIAN SLOAN, M.D.
Treasurer, GROVER H. BATTEN, M.D.

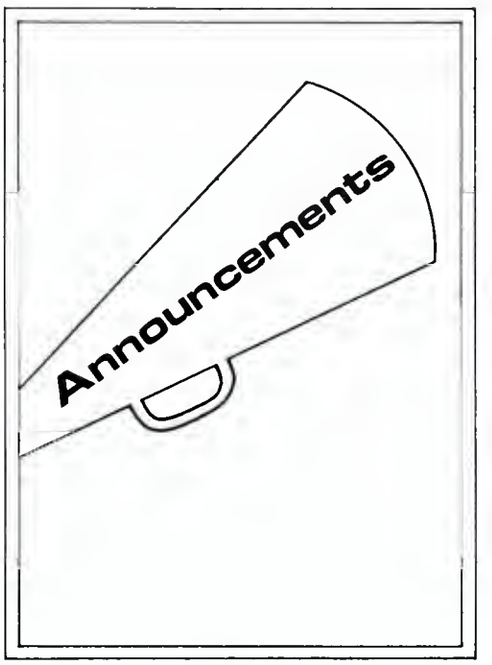
County Presidents

Hawaii, KENNETH HUGHES, M.D.
Honolulu, DOUGLAS B. BELL, II, M.D.
Kauai RIEAZI REMITIO, M.D.
Maui, CLIFFORD MORAN, M.D.
Delegate to AMA, GEORGE H. MILLS, M.D.
Alternate Delegate to AMA,
HERBERT Y.H. CHINN, M.D.

Advertising Representatives
National:
HAWAII MEDICAL ASSOCIATION
510 S. BERETANIA STREET
Honolulu, Hawaii 96813
Phone (808)536-7702
Honolulu:
LILITH JURRY, Phone 946-0053

THE JOURNAL may not be held responsible for opinions expressed in papers, discussions, communications, or advertisements. The advertising policy of the HAWAII MEDICAL JOURNAL is governed by the rules of the Council on Drugs of the American Medical Association. The right is reserved to reject material submitted for editorial or advertising columns. All material for publication must be in the hands of the editor on or before the 10th day of the month preceding publication date. Reprints of original articles will be supplied at actual cost. A reasonable number of illustrations accompanying an article will be accepted for printing. The right is reserved to ask the author to bear cost of these when it is found necessary to do so.

Copyright, 1976 by the Hawaii Medical Association, Honolulu, Hawaii. 2nd class postage paid at Honolulu, Hawaii. Office of Publication: Mabel L. Smyth Memorial Building, 510 S. Beretania St., Honolulu, Hawaii 96813.



Postgraduate Education for Pediatricians and Obstetricians

The Maternal and Child Health Program of the University of California School of Public Health at Berkeley announces postgraduate programs for pediatricians and obstetricians in the field of Maternal and Child Health and Family Planning. Program areas available at the present time include nine-month programs in Maternal and Child Health, in the Health of the School-Age Children and Youth, and Day Care and the Preschool Child. Twenty-one month programs in Care of Handicapped Children and Comprehensive Health Care, and a thirty-three month program in Perinatology are also available. These programs all lead to the degree of Master of Public Health, and tax-exempt Fellowship support is available.

Applications are now being accepted for the group entering September, 1977. For information, write to Helen M. Wallace, M.D., School of Public Health, University of California, Berkeley, California 94720.

Naval Reserve Medical Officers

Inactive medical officers of the United States Naval Reserve needed for 2 weeks ACDUTRA at medical facilities within the 14th Naval District for the months of June, July and August. Active duty medical officers on vacation, PCS, etc. If interested, contact Capt. D. R. Canete, MC USN-R-R. Naval and Marine Corps Reserve Training Center, 530 Peltier Avenue, Honolulu, Hi. 96818 or Fronk Clinic 536-6471.



Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

P-M-A
Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005

One contains aspirin. One doesn't.



Darvocet-N® 100
100 mg. propoxyphene napsylate
and 650 mg. acetaminophen

Darvon® Compound-65
65 mg. propoxyphene hydrochloride,
227 mg. aspirin, 162 mg. phenacetin,
and 32.4 mg. caffeine

Lilly

Additional information available to the profession on request.
Eli Lilly and Company, Inc., Indianapolis, Indiana 46206

500341

A vibrio disease, more common that you thought . . .

Campylobacterosis

RAY T. HUFFMAN, M.D., *Honolulu*

Infection with Campylobacter fetus is probably not as rare as previously thought. Three cases are presented which illustrate a spectrum that includes (1) a mild, self-limited, febrile illness; (2) a seven-year chronic illness, and (3) a rapidly fatal septicemia. A review of the literature indicates that the organism can become established anywhere in the body, where it produces a variable inflammatory reaction resulting in clinical manifestations of enteritis, septic arthritis, meningitis, abscess formation, cholangitis, endocarditis, pericarditis, vasculitis, or thrombophlebitis. The route of infection is usually unknown. The disease is known to occur in animals in a fashion similar to brucellosis, but animal contact is not an important feature of transmission in humans. The organism is sensitive to gentamicin and erythromycin in vitro, but the effects of treatment are equivocal.

Vibrios and related spirilla must have been among the first bacteria observed by man. They were certainly the first organisms described as regular inhabitants of the mouth, and in the last century some were classified prematurely with the organisms responsible for cholera.

As the field of microbiology became more refined, the vibrios attracted the attention of such notables as Nocard, Bang and Theobold Smith.[1,2] It was readily apparent that the microaerophilic vibrios were distinguishable from the classical aerobic vibrios of cholera biochemically and antigenically.[3] Nevertheless, partly because of an inappropriate divergence of bacteriology and clinical medicine, there evolved a somewhat misleading taxonomy which included a "non-cholera vibrio" group.[4]

Vibrio fetus was the name temporarily given to one of the organisms in this group. fortunately its assignment to a newer genus, Campylobacter [Gk. *kampos*, bent + *bakteron*, rod] has resolved most of the confusion.[5,6,7] Henceforth, in adherence to standard nomenclature, "Vibrio fetus" will be abandoned in favor of "Campylobacter fetus".

The discovery of Campylobacter fetus was made during a campaign against epizootic abortion in cattle waged by veterinary medicine at the turn of the century. The organism was isolated by McFadyean and Stockman[1] in England and independently by Smith[2] in America prior to 1920. In each instance the study was made on infected fetal calf membranes, and as the lesion was precisely the same as that caused by Brucella abortus (described by Bang 20 years earlier), the new organism remained little more than a curiosity, of no real clinical interest in the preantibiotic era.

The earliest reports of what may have been Campylobacter fetus infections in humans are vague and incomplete. Curtis[8] gave a brief but accurate description of the organism in a study of leukorrheal discharges as early as 1913, but failed to make any significant clinical correlations. In 1946, Levy[9] reported on an outbreak of enteritis in which some blood cultures showed a spirillum which also fit the description.

The first true realization that the organism responsible for abortion in cattle could infect humans was in 1947, when Vincent et al[10] isolated Campylobacter fetus from the blood stream of three pregnant cows, two of whom aborted. The following year, Ward[11] cultured Campylobacter fetus from a pustule on the cheek of a male lab worker who had been engaged in research involving the organism, demonstrating that it was capable of maintaining itself within the human body. In the ensuing decade, about 20 cases of Campylobacter fetus infections were re-

Assistant Clinical Professor of Medicine, University of Hawaii School of Medicine, Department of Medicine, Honolulu, Hawaii.
Accepted for publication July, 1975.

ported, suggesting that the disease was clinically similar to brusellosis, that anicmal contact might be a factor in acquisition, and that fever was the only consistent finding.[12,13] During the period King,[13] at the Communicable Disease Center, demonstrated rather precise serologic reactions serving for accurate identification. In 1960, Kahler[14] applied electron microscopy bringing the bacterologic studies up to date.

Campylobacter fetus is a motile, flagellated, comma-shaped or spirillar, gram-negative rod, 1 or 2 microns long and 0.3 to 0.5 microns wide. It is most readily identified by its morphology on smear preparations from culture. During early growth, the bacterium is comma-shaped, and as the culture ages, spirillar forms are more abundant. Electron microscopic observations show unipolar or bipolar flagella. The organism is microaerophilic and grows well in trypticase soy broth under increased carbon dioxide tension.

Early animal virulence studies[15] showed that the intravenous or intraperitoneal injection of a 72-hour culture failed to produce any disease in rabbits, mice, guinea pigs, or hamsters. Subsequent investigations, however, [16,17] proved that the disease could be transmitted among guinea pigs and hamsters by intraperitoneal, subcutaneous, intravaginal, and oral routes. It was also shown that the organism had a tendency to become established in the genital tract (testes and uterus), regardless of the portal of entry. The lesions produced were nonspecific and consisted mostly of necrosis and inflammatory reaction. In humans, however, the only evidence of pathogenicity was the clinical behavior of patients. Furthermore, it was often difficult to separate symptoms caused by underlying disease from those caused by infection. The variation in clinical picture can be appreciated from the following cases selected from the University of Hawaii School of Medicine hospitals. In each case the bacteriologic studies were confirmed by the Center for Disease Control in Atlanta.

Case Reports

Patient 1 (as a benign self limited disease)

A 63-year-old white man was admitted in 1970 because of fever, shortness of breath, and chest pain. The chest x-ray showed an infiltrate, and the sputum culture grew pneumococci. He was treated with Ampicillin, and became afebrile and asymptomatic by the third day. On the fifth day, he developed a temperature, spiking to 102° F. daily in spite of the stoppage of all medication. The following tests were negative or normal: urine culture, stool culture, sputum culture, malaria exam, LE prep, PBI, VDRL, stool for ova and parasites, sputum cytology and acid-fast stain, cardiac enzymes, febrile agglutinins, and an SMA-12 profile. Blood cultures on admission grew a gram-negative curved rod, ultimately identified as Campylobacter fetus. With no treatment, he became afebrile within ten days and was discharged three days later. The patient is alive and well five years later, having had no recurrence of the disease.

Patient 2 (as a chronic illness)

A 77-year old Hawaiian man developed pulmonary symptoms in 1967. In 1968, a hilar mass was discovered. Cytology on all tissue obtained by the usual methods short of thoracotomy was negative, as were appropriate studies for tuberculosis. Radiotherapy resulted in a decrease in the size of the mass. Four years later, he developed a pleural effusion which yielded a growth of Campylobacter fetus. Studies gave no evidence for tuberculosis or cancer. During the following two years he developed nodular densities in the lung fields and bone scanning revealed increased uptake in the right knee and thoracic vertebrae. During this time, his major problem was hemoptysis and anemia. In 1974, 250 mililiters of dark red fluid, aspirated from the pleural space. showed only inflammatory cells. He died in a nursing home at age 84, seven years following the onset of his illness. No autopsy was performed.

Patient 3 (in association with a debilitating illness)

A 49-year old man, with malabsorption of four years duration following extensive resection of the small bowel for volvulus and biopsy-proven cirrhosis, was admitted because of lethargy. His pulse was 100, temperature 97.4° F, respiration 20, and blood pressure 130/70. There was moderate pitting edema of the extremities. His hematocrit was 32, white cell count 32,000, with a shift to the left. The serum bilirubin was 3.5 mg%, total protein 5.8 gm% and albumin 2.1 gm%. The chest x-ray showed a right upper lobe infiltrate. Three blood cultures taken at half-hour intervals were positive for Campylobacter fetus, showing disc sensitivity to gentamicin and cephalosporin, which were included in his therapy. In spite of antibiotics and supportive measures, he died on the tenth hospital day. The autopsy showed cirrhosis and extensive broncho-pneumonia. No organisms could be identified in the post mortem tissues.

Discussion

Over the past twenty years, Campylobacter fetus has been implicated in dysentery,[18,19] septic arthritis,[20,21] meningitis,[22,23,24] endocarditis,[25,26] pericarditis,[27] cholangitis,[26] lung abscess,[20] thrombophlebitis,[12,14,15] and intracranial hemorrhage.[28] The infection has been found in cases of abortion[30] and in newborns, where it appears to have been transmitted from the mother.[31] The organism has been cultured from nearly every tissue of the body including placenta and aborted fetuses.[18-32] While Spink[12] originally emphasized

contact with animals, subsequent observations have generally failed to support the concept that the disease is so transmitted. The discovery that up to 17% of slaughtered cattle and sheep may harbor the organism[33] has lead to the speculation that raw meat may be a source of infection.[26,34] Again, such a relationship appears to be exceptional. In animal experiments[16,17] there is evidence that the disease can be transmitted by coitus among guinea pigs. In cattle, the male appears to asymptomatically harbor the organism in the genitalia.

These observations have lead to the postulation of a venereal route of infection in humans.[35] Evidence of this is lacking in all cases published to date. Although modern bacteriologic techniques have demonstrated a close relationship between Campylobacter fetus strains cultured from humans and those from cattle,[36] one must conclude that campylobacterosis may occur in man or in animals, and there the relationship ends. Nowadays, most of the infected individuals are urban dwellers and the source and route of infection are unknown. The lesions produced in association with the infection are nonspecific inflammatory reactions, frequently involving blood vessels, which accounts for thrombophlebitis and a surprising number of strokes.[23,28] About one-fourth of cases display neurological disease, mostly meningoencephalitis. The organism can sometimes be seen in microscopic sections.[24] Usually, as in patient 3, no pathogen is found at autopsy.

There has been a major emphasis on the high incidence of predisposing debilitating disorders in patients with campylobacterosis.[37-41] A close analysis of the situation suggests that while the disease is more impressive in this group, it probably occurs with equal frequency in otherwise healthy persons where it runs a mild self limited course as in patient 1. Unlike most opportunistic organisms, Campylobacter fetus has rarely, if ever, been isolated from mixed flora of man. Bokkenhauser[42] found no seroreactors among 184 healthy men, and of 401 unselected hospital patients only four had measurable serum titers.

One of the most interesting and poorly understood presentations of the disease is that of a chronic illness. Bacteremia of long duration has frequently been reported.[12,22,29] Patient 2 was thought to have metastatic lung cancer or tuberculosis. This initial impression seems highly unlikely in view of the seven year course that followed. It is unfortunate that no autopsy was obtained in this case, but the clinical course is not unlike many of those previously reported and suggests an altered host response in the elderly.

The effects of treatment are not at all well documented. Most reports indicate variable sensitivity of the organism to most antibiotics, except for a fairly consistent resistance to penicillin. The most recent study by Butzler et al[43] showed gentamicin and erythromycin to be the most active drugs against Campylobacter fetus in vitro. Lower activity was noted with chloramphenicol and streptomycin. Tetracycline and kanamycin were even less effective. The susceptibility to ampicillin was variable. More than 90% of the strains were resistant to cephalothin. The application of in vitro sensitivities to the clinical situation is questionable. As illustrated in patients 1 and 3, the severely ill fail to respond to the selected antibiotics and those with milder symptoms seem to recover with no treatment at all. Some authors have stated that failure of treatment may be the result of stopping antibiotics too early and have recommended prolonged therapy.[32,34] In view of the organism's ability to become established in inaccessible areas like the central nervous system,[22,23,24] joint spaces,[20,21] and the biliary tract,[26,32] such a recommendation certainly deserves further consideration.

Campylobacterosis is not as rare as generally believed. The U.S. Public Health Service receives about two isolates of Campylobacter fetus for identification each month. The relative ease with which case material can be collected suggests that the disease is probably present in any major hospital with a frequency of one or two cases a year.

REFERENCES

1. McFadyean J, Stockman S: Epizootic Absorption in Cattle. London, His Majesty's Stationary Office, 1909, Vol. 3
2. Smith T: Spirilla Associated with Disease of Fetal Membrane in Cattle. *J Exper Med* 28:701-719, 1918
3. White W: Human Vibriosis. Indigenous Cases in England. *Br Med J* 2:283-287, 1967
4. Thorsteinsson S, Minuth J, Musher D: Clinical Manifestations Halophilic Non-Cholera Vibrio Infections. *Lancet* 2:1283-1284, 1974
5. Barrow G, Furniss A: Halophilic Non-Cholera Vibrio Infections. *Lancet* 1:172, 1975
6. Sutter VL, Attebery HR, Finegold SM: Gram-Negative Nonspore-forming Anaerobic Bacilli, Chapter 41, Manual of Clinical Microbiology, Second Edition, Washington, D.C., American Society for Microbiology, 1974, p. 390
7. Taper M: Halophilic Non-Cholera Vibrio Infections. *Lancet* 1:172-173, 1975
8. Curtis A: A Motile, Curved, Aerobic Bacillus in Uterine Discharges. *J Infect Dis* 12:165-169, 1913
9. Levy AJ: A Gastroenteritis Outbreak Probably Due to a Bovine Strain in Vibrio. *Yale J Biol and Med* 18:245-258, 1946
10. Vinzent R, Dumas J, Picard N: Septicemie Grave Au Cours de la Grossesse, Due a un Vibrion. Avortment Consecutif. *Bull Acad Nat Med* 131:90-92, 1947
11. Ward BQ: The Apparent Involvement of Vibrio Fetus in an Infection of Man. *J Bact* 55:113-114, 1948
12. Spink WW: Human Vibriosis Caused by Vibrio Fetus. JAMA 163:180-182, 1957
13. King EO: Human Infections with Vibrio Fetus and a Closely Related Vibrio. *J Infect Dis* 101:119-128, 1957
14. Kahler RL, Sheldon H: Vibrio Fetus Infection in Man. *N Eng J Med* 262:1218-1222, 1960
15. Jackson J, Hinton P, Allison F: Human Vibriosis. *Amer J Med* 28:986-994, 1960

16. Ristic M, Morse EV: Experimental Vibrio Fetus Infection in Guinea Pigs. Bacterologic Aspects. *Am J Vet Res* 14:399-404, 1953
17. Ristic M, Morse EV, Wipf L, et al: Transmission of Experimental Vibrio Fetus Infection Among Guinea Pigs and Hamsters. *Am J Vet Res* 15:309-315, 1954
18. Mandel AD, Ellison RC: Acute Dysentery Syndrome Caused by Vibrio Fetus. JAMA 185:536-539, 1963
19. Park C, McDonald F, Twohig A, et al: Septicemia and Gastroenteritis Due to Vibrio Fetus. *South Med J* 66:531-533, 1973
20. King S, Bronsky D: Vibrio Fetus Isolated from a Patient with Localized Septic Arthritis. JAMA 175:1045-1048, 1961
21. Kilo C, Hageman P, Marzi J: Septic Arthritis and Bacteremia Due to Vibrio Fetus. *Amer J Med* 38:962-971, 1965
22. Collins H, Blevins A, Bentner E: Protracted Bacteremia and Meningitis Due to Vibrio Fetus. *Arch Intern Med* 113:361-364, 1964
23. Gunderson CH, Sack GE: Neurology of Vibrio Fetus Infection. *Neurology* 21:307-309, 1971
24. Burgert W, Hagstrom J: Vibrio Fetus Meningoencephalitis. *Arch Neurol* 10:196-199, 1964
25. Loeb H, Bettag J, Yung N, et al: Vibrio Fetus Endocarditis. *Amer Heart J* 71:381-386, 1966
26. Chung Y, Lee S: Vibrio Fetus Human Infection. Isolation from a Subacute Bacterial Endocarditis Case. *Yonsei Med J* 11(2):126-130, 1970
27. Killan H, Crowder J, White A, Edmonds J: Pericarditis Due to Vibrio Fetus. *Am J Card* 17:723-728, 1966
28. Darrell JH, Farrel BC, Mulligan RA: Case of Human Vibriosis. *Br Med J* 2:287-289, 1967
29. Lawrence R, Nebbie A, Levin S: Lung Abscess Secondary to Vibrio Fetus, Malabsorption Syndrome and Acquired Agammaglobulinemia. Chest 60:191-194, 1971
30. Hood M, Todd J: Vibrio Fetus. A Cause of Human Abortion. *Amer J Obstet Gynec* 80:506-511, 1960
31. Willis M, Austin W: Human Vibrio Fetus Infection. *Am J Dis Child* 112:459-462, 1966
32. Swartz R, Hirsch E, Mule J: Antral Mucosal Diaphragm. Clinical and Roentgen Characteristics with First Reported Case of Vibrio Fetus in Human Bile. *Am J Gastroenterology* 45:366-373, 1966
33. Byner JH, Frank AH, O'Berry PA: Vibrio Infection of the Digestive Organs of Cattle. *Amer J Vet Res* 25:1048-1050, 1964
34. Soonattrakul W, Andersen B, Bryner J: Raw Liver as a Possible Source of Vibrio Fetus Septicemia. *Am J Med Sci* 261:245-249, 1971
35. Lawrence GD, Biggs RD, Woodward TE: Infection Caused by Vibrio Fetus. *Arch Intern Med* 120:459-464, 1967
36. Bryner J, Ritchie AE, Booth GD, et al: Lytic Activity of Vibrio Phages on Strains of Vibrio Fetus Isolated from Man and Animals. *Applied Microbiology* 26:404-409, 1973
37. Bokkenhauser V: Vibrio Fetus Infection in Man. *Amer J Epidemiology* 91:400-409, 1970
38. Toala P, McDonald A, Kass EH: Septicemia Caused by Vibrio Fetus. *Arch Int Med* 126:306-308, 1970
39. Franklin B, Ulmer PD: Human Infection with Vibrio Fetus. *West J Med* 120:200-204, 1974
40. Dolev E, Altman G, Padeh B: Vibrio Fetus Septicemia. *Israel J Med Sci* 7:1188-1191, 1971
41. Bokkenhauser V: Vibrio Fetus Infection in Man. A Serologic Test. *Infection and Immunity* 5:222-226, 1972
42. Butzler J, Dekeyser P, LaFontain T: Susceptibility of Related Vibrios and Vibrio Fetus to Twelve Antibiotics. Antimicrobial Agents and Chemotherapy 5:86-89, 1974

New from Lilly/Dista Research

NALFON®

fenoprofen calcium

300-mg.* Pulvules®

DISTA

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46206

Additional information available to the profession on request.

*Present as 345.9 mg. of the calcium salt of fenoprofen dihydrate equivalent to 300 mg. fenoprofen.

600091



H. Tom Thorson

This issue of the Newsletter will be devoted largely to the new statute covering malpractice insurance. At the time of writing it had not been signed by the Governor but we have every reason to believe that he will sign the bill in due course.

The bill covers a number of subjects. The original bill was drafted by a committee of eighteen working with the Department of Regulatory Agencies. The committee was made up of doctors, lawyers, labor representatives, hospital people, insurance people, and the public. The committee worked eight months in preparation for the presentation to the legislature.

The omnibus bill covered tort law, statute of limitations, mediation panels, patients compensation fund, peer review, medical practice act amendments, and the insurance system itself including mandatory reporting. Any and all of these items can be tremendously complex. We did not get all that we asked for . . . we got some things we didn't ask for, or want . . . but we did get some very important parts of the bill. With the basics behind us, we can return to the next legislature with renewed strength and seek changes that are necessary. We did get the patients compensation fund that will help us to stabilize our premiums. This was probably the single most important element.

We got the mediation panels. They are not exactly what we had in mind but close enough so that we can't complain too much.

We got almost exactly what we wanted in the strengthening of the Board of Medical Examiners by changes in the medical practice act and also gained the opportunity to have input into the selection of the board of examiners. We did get a pretty good modification and definition of the law covering "informed consent."

We did not get our recommended modification of the law defining "*res ipsa loquitur*."

We were unsuccessful in putting a reasonable limit on contingency fees.

We also got one thing we didn't want in the nature of a financial responsibility clause requiring doctors to demonstrate financial responsibility before a license can be granted. This is a bad one and perhaps unconstitutional—we don't know, but it will work a hardship and create some inequities.

Continuing education will be required for license renewal. We were already headed down this road along with a number of other states. We think we can live with this.

We did not get our modification of the statute of limitations. We did not get our requested limit on awards for "pain and suffering." We got most of the reporting requirements that we sought so that more information will be available for claims research. The lawyers escaped the reporting requirements, pleading "client confidence." All in all, the law has more good than bad in it and we will have another crack at it before the full impact of it is felt in the bad areas.

What do some of the major things mean?

The patients compensation fund will provide a built-in guaranteed reinsurance market. All judgments above $100,000 will be paid from the fund, up to $5,000,000. The fund will be developed by contributions from the insured providers base on a percentage of their basic ($100,000) coverage premium. It appears at this time that those that are carrying $1,000,000 coverage now will get a reduction in premium in September. Those carrying only $100,000 at present will probably be faced with an increase. We have five years to build the fund to its $5,000,000 maximum.

The mediation or conciliation panels should do much to avoid the long and costly process of court trials. All suits must go to a panel before being allowed to go to court. Hopefully the panels will be able to resolve most of the cases. Either party, however, may continue on to trial if dissatisfied with the panel decision as to the nature of the decision or the recommended amount of an award.

Much remains to be done. Meetings are being held with the Department of Regulatory Agencies relative to the drafting of rules and regs on many parts of the bill. We are assured by Mr. Minami that we will have a large level of input into the rules.

Mistakes may be made and corrections will be needed, but we have one very good start in getting some kind of a handle on the problem of escalating costs. Peer review is the society's problem. There is no doubt that the reporting requirements placed on the peer review committees will have a tremendous impact on the way we now conduct peer review. It may require by-laws changes and a whole restructuring of our committees and procedures. Peer review will become a prerequisite to being insured. Further details will be distributed as the picture becomes clearer.

The above isn't a total summation but does give most of the salient features.

OCHAMPUS wants a Medical Officer—Station—Denver. Closing date is June 4, 1976. Contact Civilian Personnel Office, Attn. C. Emmett, Fitzsimons Army Medical Center, Denver, Colorado 80204.

Dr. Sam Allison was elected to life time membership in the Alumni Association, U. of Oregon Medical School.

Visiting physician from Chicago would like to house sit—for info call Dr. Bill McCarberg—734-4998 Honolulu.

Family Practitioner with license available for locum tenens in September. Call Dr. West—523-2311.

PDRs needed. If you have an outdated PDR give Dr. Sharon Bintliff a call at Children's Hospital.



. . . Health care costs

The President's Council on Wage and Price Stability in Washington, D.C., announced in April that: "A monopoly-like control by physicians, of medical services, coupled with a frequently 'passive' role by patients in purchasing medical care are helping to push health care costs up at record speed."

Such a statement makes absolutely no sense. "Physicians have a monopoly on health services—of course! Just as lawyers have a monopoly in court; senators and representatives from the 50 states have a monopoly in the Congress. The only reason plumbers, carpenters and mechanics don't exercise monopolies in their respective fields is because many people are do-it-yourself experts. May heaven help us if any Tom, Dick and Harry tries to do-it-yourself with cardiac catheterization! Most people, to the contrary, are afraid even to take a temperature reading, give themselves an enema or an aspirin.

As for the patients being "passive"—@#☆$¢% (expletive deleted)! Is the patient supposed to be resisting aggressively what highly-trained and usually thoroughly competent medical experts conclude is best for him?

There is, however, the modern-day availability of fantastically effective technological advances in medicine that the patient demands, and that the physician cannot and will not deny him. But . . . these cost a lot of money. There are many bureaucrats and agencies in government who don't realize that the "control" of health care costs equates with "denial" of health care services.

A couple of recent actual examples:

Mrs. A, housewife and mother of four teenagers and beyond, develops angina. She is known to be diabetic, hypertensive, overweight with an abnormal EKG. She has been medically controlled for several years, but now develops increasing exertional angina. A TST suggests serious myocardial insufficiency and a cardiac cath demonstrates beautifully the coronary lesion. Surgery—a by-pass vein graft—successfully corrects the problem. Complications are quickly and properly managed. After several months, she returns to a non-disabled status and returns to her duties. The total bill: $12,000, of which private insurance pays $9,000. Her middle-income family absorbs the $3,000 out-of-pocket portion in time, as a manageable extra cost. Had they been on Medicaid, the government (we-the-people) would have picked up the tab, probably paying the several physicians, the hospital and the ancillary services at a discounted rate of around 60%. These "providers" would have had to absorb about $4,800 and passed the deficit on in increased charges to their other private patients.

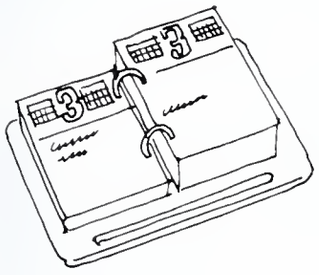
Mr. B, a young executive with a beginning family, has symptoms that are equivocal, but that lead inevitably to a TST, which, unfortunately perhaps, is also equivocal. The "gray area" perforce leads to a cardiac cath. Hurrah! It is very normal. He returns to his responsible position; his employer is happy not to have lost an expensively-trained and competent staffer. The cost of this little medical digression: $1,500, again mostly covered by private insurance, all just to prove "You say there is nothing wrong with me, Doc?" Would these same amenities have been offered a peon, or a buck-private in the rear ranks, or a bum, or a "minority" person? Yes! Repeat, Yes!

Mr. C, Medicare age, suffers a peculiar stroke. There is evidence of prior deterioration in cerebration. The CSF suggests the possibility of something else. The new EMI CAT-Scan presents a beautiful and unequivocal picture of an

intra-cerebral hemorrhage in the appropriate area. The diagnosis is made without a lot of old-fashioned other invasive tests. But, it cost $275—for just a few black & white prints! The government may frown: "Why such an expensive test? Couldn't you have saved some pennies somewhere? What's the matter with your PSRO?"

Such are the makings of modern medicine. They are denied to none, by us physicians. Our patients are well aware of their existence; they demand the best, and the cost be hanged.

J. I. F. R.



Continuing Medical Education

CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m.

Kaiser Hospital

(Contact CME Dept. for further information)

Kauikeolani Children's Hospital

1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program

Kapiolani Maternity Hospital

1. Grand Rounds, Wednesdays, 7:30-8:30 a.m.
2. Resident Conference, Tuesdays (except 1st), 1:00 p.m.
3. Ob-Gyn Department Meeting, 1st Tuesday, 1:00 p.m.
4. UH Seminars, Wednesdays, 3:30 p.m.
5. Perinatal Conference, Thursdays, 3:30 p.m.
6. Tumor Board, 1st & 3rd Fridays, 1:00 p.m.
7. Oncology Conference, 4th Friday, 1:00 p.m.
8. Visiting Professor Program

Kuakini Hospital

1. Hematology Rounds, Monday, 1:00-2:00 p.m.
2. Gastroenterology, Tuesday, 8:00-9:00 a.m.
3. Oncology Conference, Thursday, 8:00-9:00 a.m.
4. Endocrine Conference, 2nd Wednesday each month, 1:00-2:00 p.m.
5. Medical Statistics, 3rd Tuesday each month, 1:00-2:00 p.m.
6. Renal Conference, Wednesdays, 1:00-2:00 p.m.
7. Kidney Biopsy Conference, Tuesdays, 1:00-2:00 p.m.
8. Visiting Professor Program
9. G.I. Rounds, Tuesdays, 8:00 a.m.
10. Infectious Disease Conference, Thursdays, 1:00 p.m.

The Queen's Medical Center

(Contact Medical Staff Office for further information)

St. Francis Hospital

1. Medical Grand Rounds, Tuesdays (4th & 5th), 1:00-2:00 p.m.
2. Surgical Grand Rounds, Fridays (except 4th), 7:30-8:30 a.m.
3. Tumor Conference, Mondays, 7:30-8:30 a.m.
4. Visiting Professor Program
5. Clinical Pathology Topics, Mondays, 10:00-11:00 a.m.
6. Microslide Conferences, Tuesdays, 8:30-9:30 a.m.
7. Bone Marrow Pathology, Tuesdays, 2:00-3:00 p.m.
8. Basic Science Review & Research Conference, Thursdays, 1st & 3rd, 8:00-9:00 a.m.
9. Psychiatric Case Conference, Tuesdays & Fridays, 8:00-9:00 a.m.
10. Psychiatry for the Non-Psychiatrist, Tuesdays, 10:00-11:00 a.m.
11. Psychiatry Teaching Rounds, Thursdays, 9:00-10:00 a.m.
12. Medical Psychiatric Joint Teaching Rounds, Fridays, 11:00-12:00 noon
13. Surgical Mortality & Morbidity Conference, last Friday, 7:30-8:30 a.m.
14. Saturday Teaching Rounds, Saturdays (except 4th), 7:30-8:30 a.m.

Straub Clinic & Hospital

1. Medical Grand Rounds, first Thursday, 7:00 a.m.
2. Surgical Mortality & Morbidity, 4th Thursday, 7:00 a.m.
3. Quarterly Professional Staff Meetings, (Jan., Apr., Aug., Nov.), 4th Monday, 7:30 p.m.

Wahiawa General Hospital

1. Noon Seminars, 2nd Friday & 4th Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:30 p.m. & 2nd Wednesday, 12:30 p.m. of each month in the Mabel Smyth Building. Contact HMA Office as dates are subject to change.

SPECIAL EVENTS

May 16-17 18-19	Seventh Hawaii Emergency Physicians Seminar, Pacific Building-Kaiser Hospital. Contact J.K. Sims, M.D. at 538-0911.
May 12	"Recent Advances in Suicidology," by Edwin Shneidman, Ph.D., Professor of Thanotology, sponsored by the Hawaii Psychiatric Society at

7:30 p.m., Mabel Smyth Auditorium. 1½ hours credit. Registration: $5.00 for non-members.

May 18 "The Clinical Psychopharmacological Usage of Anti-Psychotic Agents on a Long Term Basis," Dr. C. Harold Wollack, M.D., M.P.H.; Hawaii Psychiatric Society, 7:30 p.m., Mabel Smyth Lanai, 1½ hours credit. Registration: $5.00 for non-members. For further information contact Dr. Leonard Jacobs via 524-7575.

May 13 American Ophthalmological Society, Mauna Kea Beach Hotel. Contact Dr. Robert Hollenhorst, c/o Mayo Clinic, 200 Southwest First Street, Rochester, Minnesota 55901.

May 25 Minicourse on Orthopedics at Wahiawa General Hospital Dining Room, 12:30 luncheon meeting and 6:00 p.m. dinner meeting. Contact Dr. Richard Tesoro for further information. Four hours instruction.

June 20-25 South Pacific Commission Cancer Seminar at the Pagoda Hotel, sponsored by the American Cancer Society. Contact: John R. Watson, M.D. or Kay VanSant at 531-1662.

August 9-13 Emerging Medical, Moral, and Legal Concerns sponsored by St. Francis Hospital and the National Kidney Foundation at the Princess Kaiulani Hotel; 18 hours credit; for more information contact Dr. Arnold Siemsen, 948-7433.

August 14-25 19th Annual Postgraduate Refresher Course presented by the University of Southern California School of Medicine and University of Hawaii School of Medicine; Sheraton-Waikiki Hotel; Workshops throughout the morning. Registration $180.00 for Honolulu portion of meeting.

August 23-24 USC Course on the islands of Kauai and Maui at the Kauai Surf and Royal Lahaina Hotel respectively; 7:30 a.m.-12 noon. Registration fee unknown. For further information contact Phil R. Manning, M.D., University of Southern California, School of Medicine 2025 Zonal Avenue, Los Angeles, Calif. 90033.

August 28-September 6 Therapeutics Update sponsored by Postgraduate Education for Physicians in cooperation with the University of California in San Francisco; Maui Surf Hotel; 8:30-11:30 a.m.; Tuition $100; 15 hours Category 1 credit. For further information contact Barry S. Ramer, M.D., Daman-Nelson Travel, 115 Mission Street, San Francisco, California 94105.

October 3-8 VI Asian Pacific Congress of Cardiology at the Sheraton-Waikiki; contact Dr. Morton Berk for further information at 537-2211.

October 18-22 American College of Physicians — Workshop in Internal Medicine; Ilikai Hotel; contact Dr. John Kim for further information at 949-5811.

October 25-29 Hawaii Medical Association Annual Meeting; Ilikai Hotel; contact Bess Chang for further information at 536-7702.

The seminars on "Sexual Counseling: Office Management of Sexual Problems" sponsored by the ACOG and University of Hawaii will be held on the following dates: (20 hrs. credit)

October 18-22 December 20-24
November 22-26

For further information, write to: American College of Obstetricians & Gynecologists, Department of Continuing Education, I. E. Wacker Drive, Suite 2700, Chicago, IL 60601

Programs sponsored by the University of Southern California:

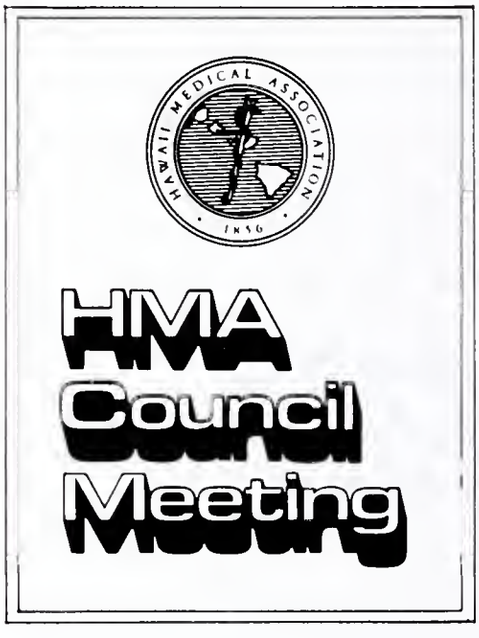
May 23-30 Nephrology, at Maui Surf Hotel, Maui.

June 13-20 Orthopedic Review, at Mauna Kea Beach Hotel, Kamuela.

For further information, contact: Phil R. Manning, M.D., Associate Dean, Postgraduate Division. USC School of Medicine, 2025 Zonal Ave., Los Angeles, CA 90033.

OUT OF STATE

For information on any out-of-state programs or courses, refer to August 11, 1975 Supplement to JAMA or call the HMA Office.



February 27, 1976, 6:30 p.m. Mabel Smyth Lanai

CALL TO ORDER

The meeting was called to order by President William W. L. Dang. Present were Drs. Calvin C. J. Sia, Winfred Y. Lee, R. Varian Sloan, Grover H. Batten, George H. Mills, Herbert Y. H. Chinn, Ann B. Catts, George Goto, John Kim, Rowlin Lichter, Carl H. Lum, J.I.F. Reppun, Arnold Siemsen, Sakae Uehara, Peter Kim, Douglas Bell II, Clifford Moran, Kenneth Hughes, Alan Pavel, and Roy Kuboyama. Also present were Mr. V. Thomas Rice and Mrs. Jerome L. Tucker.

MINUTES

The minutes of the January 16, 1976 meeting were accepted as circulated.

TREASURER'S REPORT

The financial statement for December 1975 was approved subject to audit.

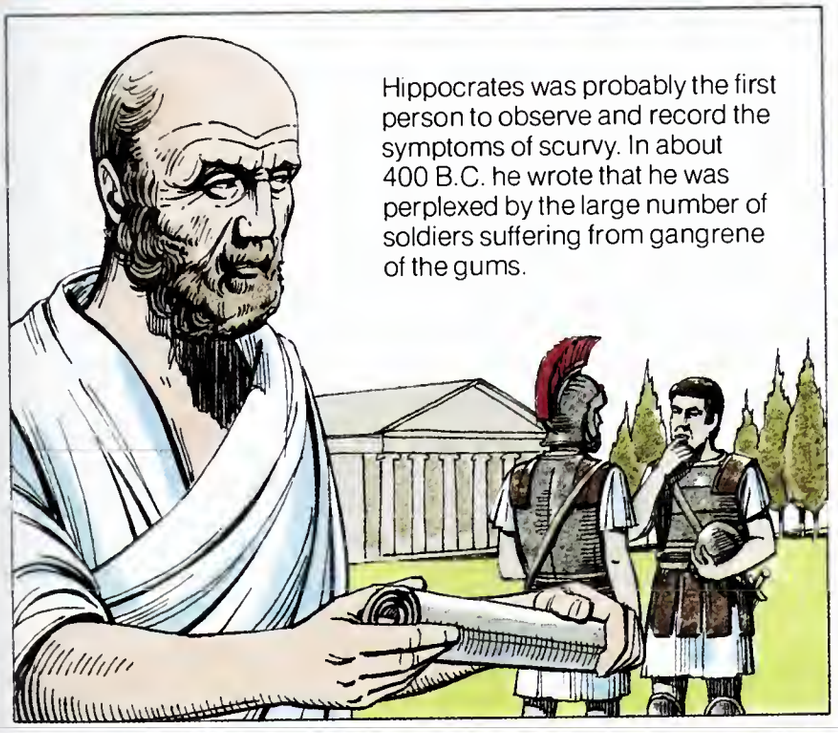
The "Dang Plan": Recommendations from the Finance Committee and a resolution submitted by Drs. Sakae Uehara and Herbert Chinn relative to the Dang Plan were reviewed in detail. The amended resolution, which incorporates Finance Committee recommendations, was accepted as follows:

WHEREAS the Council of the Hawaii Medical Association recommended that Option 5 of the Report of

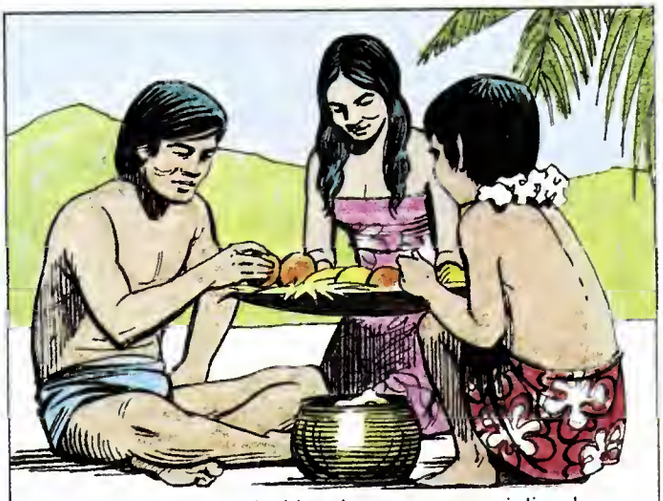
The ALLBEE® with C Scrapbook of Vitamin Facts & Fallacies

Northern and Central Europeans must obtain their vitamin C primarily from cabbage because these countries don't have a Florida or California as a source of citrus fruits. These inhabitants get about twice as much ascorbic acid when they eat their cabbage raw as when they boil it.

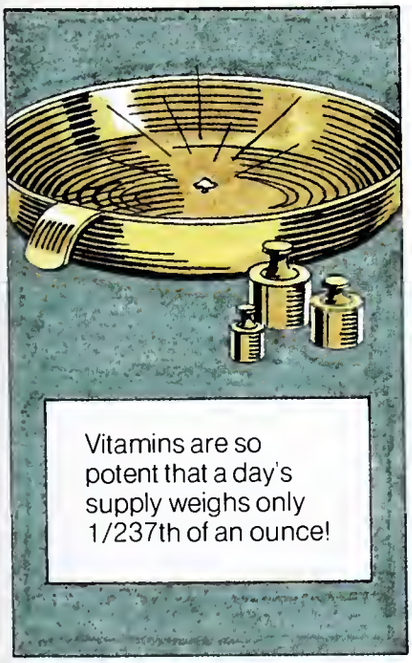




Hippocrates was probably the first person to observe and record the symptoms of scurvy. In about 400 B.C. he wrote that he was perplexed by the large number of soldiers suffering from gangrene of the gums.



People in more primitive, less commercialized societies often eat better balanced diets than affluent Americans. These natives instinctively choose nourishing foods because their bodies tell them what they need. The dietary habits of Americans are often influenced by television commercials that appeal to our wants instead of our needs.



Vitamins are so potent that a day's supply weighs only 1/237th of an ounce!



Look for the monogram "AHR" on every Allbee with C capsule. It is your assurance that this is the original and genuine product and not an imitation.

Available on your prescription or recommendation

ALLBEE® with C

High Potency B-Complex and Vitamin C Formula



A.H. Robins Company, Richmond, Va. 23220 A·H·ROBINS



Spasm reactor?

Donnatal®!

	each tablet, capsule or 5 cc. teaspoonful of elixir (23% alcohol)	each Donnatal No. 2	each Extentab
hyoscyamine sulfate	0.1037 mg.	0.1037 mg.	0.3111 mg.
atropine sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
hyoscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
phenobarbital	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg.	(¾ gr.) 48.6 mg.
(warning: may be habit forming)			

Brief summary. Adverse Reactions: Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Contraindications: Glaucoma; renal or hepatic disease; obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); or hypersensitivity to any of the ingredients.

A·H·ROBINS A. H. Robins Company, Richmond, Virginia 23220

the Ad Hoc Committee on Future Recommendations be given top priority by the House of Delegates in 1975, and

WHEREAS top priority was given by the House of Delegates to Option 5, and

WHEREAS the House of Delegates adopted Resolution No. 23 (the "Dang Plan") to implement the development of monies necessary for Option 5, therefore,

BE IT RESOLVED *that* all monies collected to carry out Resolution No. 23, less the amount necessary to repay loans for the year and less the amount actuarily determined at appropriate intervals to be held for reserves be used to pay off the principal outstanding in the year these monies are collected,

That all monies collected from the Ward Street property, less the amount needed for repairs, improvements, insurance and other expenses, be used to pay off the principal outstanding in the year these monies are collected,

That any other monies of HMA over the amount of one year's operating expense be applied to the principal outstanding in that year with approval of the House as recommended by the Finance Committee,

That, when the principal is paid in full, loans from members be repaid as rapidly as economically feasible in the order of those members who paid in the total amount first to be repaid first, unless any of these members prefer repayment deferred as provided in Resolution No. 23,

That, when the principal is paid in full, monies accumulated are to be used to repay all other members until no more monies need be collected from new members as determined by the House of Delegates,

That, when the principal is paid, the declining amount of loan requirement from new members each year, be instituted.

REPORTS FROM COMMITTEES AND COMMISSIONS

A. Professional Liability Insurance Committee: Dr. Pavel reported that Argonaut Insurance Company has approached him regarding the possibility of utilizing the services of individual members of the Professional Liability Committee, or the Hawaii Medical Association, as consultants with hourly compensation from Argonaut. Argonaut has been pleased with the review functions of the Professional Liability Committee, but the recent volume of cases has increased and require more help than the Committee can give at this time. The Committee will still function as a body however, and difficult cases would be brought before the full committee meetings. Dr. Pavel recommends that the Council approve Argonaut's request. There was concern expressed as to the functions of the different peer review committees on the county society level and the possibility of ramifications that this function is not in line with committee work.

ACTION:

It was voted to assign three appropriate members of the Council to review Argonaut's request and to report its findings at the next Council meeting.

B. Woman's Auxiliary: Mrs. Tucker reported that the Woman's Auxiliary to the HMA had a workshop on medical malpractice recently which was well attended. The Health Education Office of the State Department of Health released a listing of commonly used English-Japanese phrases which would be helpful in a doctor's office or hospital. Mrs. Tucker distributed these to members of the Council.

C. Medical Education: Dr. Lee pointed out that some method of bookkeeping needs to be established for keeping attendance records for physicians who attend various meetings. One suggestion is that hospitals keep their own attendance records which is then reported to the HMA's central file. Dr. Lee feels that the Continuing Medical Education Committee should be more directly involved in the objectives and methods of carrying out the scientific program of the HMA Annual Meeting to satisfy continuing medical education requirements. The President directed Dr. Sloan to coordinate activities between the two committees.

D. Public Health: Dr. Kuboyama reported that the Communicable Disease Committee had voted to recommend to the Council to support mandatory premarital testing for proof of rubella vaccination. Since there was no second to Dr. Kuboyama's motion for support of this recommendation, the motion died on the floor.

E. Public Affairs: Dr. Lichter reported that Tel-med will go into full swing in a few weeks. The TV-Radio Committee will be cooperating with Punahou School in developing a series of spot announcements on health advertisements to be used on major television stations. The Committee will also assist in developing health subjects for ETV medical specials this year.

F. Health Service and Care: The Community Health Committee will be reviewing the proposed criteria for intermediate care which DSSH sent to all health related organizations for comments. It is felt that most of the proposed intermediate care criteria is too close to the criteria for skilled nursing care. DSSH has extended the deadline for these comments to May 5, 1976 which should allow time to consider questionable points with providers and representatives of government agencies before final development of the criteria.

G. Legislation: HMA legislative testimonies prepared to date and the Omnibus bill relating to medical malpractice, H.B. 2700 and S.B. 2332, were circulated. HMA's stand on compulsory insurance for licensure was discussed.

ACTION:

It was unanimously voted that medical competence and licensure should not be determined on the basis of a physician's financial situation with an insurance company.

H. Emergency Medical Service: The present EMS contract with the Department of Health regarding the training program for emergency medical personnel on neighbor islands has been completed. HMA will probably continue the training program on a long term basis, but standards should be set up by the Department of Health. The planning grant must be forwarded to Washington, D.C., by April 15 to become effective by July 1.

I. PL-93-641: National Health Planning and Resources Development Act of 1974: Governor Ariyoshi requested nominations from HMA for names of physicians to serve on the Statewide Health Coordinating Council (SHCC) to advise the State Health Planning and Development Agency (SHPDA).

ACTION:

It was voted to submit the names of Dr. William W. L. Dang and Dr. Calvin C. J. Sia to the State Coordinating Council.

J. Cancer Center: A copy of a letter from Dr. Dang to Dr. Herbert Chinn, as chairman of the Executive Committee of the Cancer Center, was circulated for Council review. The letter outlined some of HMA's concerns regarding the development of the clinical program under the Cancer Center as well as some of the misapprehensions which occurred during a national cancer center site visit in May 1975 when clinicians were excluded. The Cancer Center Executive Board was asked to review the points raised in the letter.

K. PSRO: Dr. Lee announced that it appears PacPSRO will become operational in June 1976. Plans call for statewide meetings on utilization review and peer review. It was noted that there are some difficulties in coordinating DSSH programs in PSRO activities. DHEW will meet with state officials in the near future.

OTHER BUSINESS

A. 320 Ward Avenue: Dr. Dang reported that a realty company is interested in renting the rooms at Ward Avenue which the Bureau of Medical Economics originally planned on occupying.

B. Long-Range Planning Committee: As requested by the Council at its January 16th meeting to have the President appoint a committee to manage capital funds and building

income, Dr. Dang reported that the Long-range Planning Comittee will be composed of members of the Finance Committee and the Ad Hoc Building Management Committee.

C. Hawaii Health Resources and Statistics, Inc.: The purpose of this joint corporation formed by HMA and the Hospital Association of Hawaii was to develop a project for a mutual insurance company to underwrite malpractice insurance for hospitals and doctors. A feasibility study is underway and various avenues are being investigated.

D. HMA Delegation to AMA: As of December 31, 1975, active HMA membership exceeded 1,000 members, entitling the HMA to send two delegates to the AMA House of Delegates and Clinical Sessions. AMA has asked for names of HMA's delegates. Dr. Herbert Y. H. Chinn was elected the second delegate at the January 16, 1976 meeting.

ACTION:

As requested by the Council, the President appointed Dr. William W. L. Dang as alternate delegate pro tem and Dr. R. Varian Sloan as second alternate delegate pro tem until the next HMA House of Delegates meeting.

NEW BUSINESS

The California Medical Association requested support from HMA on Resolution No. 86-76 which condemns the use of the social security number as a universal number identifier.

ACTION:

It was voted to support Resolution 86-76 and to notify CMA of our support.

ADJOURNMENT

The meeting adjourned at 10:30 p.m.

R. Varian Sloan, M. D.
Secretary

Book Reviews



Philadelphia Medica

By John Francis Marion, 144 pp., 39 color photographs. Stackpole Books, Cameron and Kelker Streets, Harrisburg, PA 17105. Price: $4.95.

Philadelphia, surely one of American medicine's most significant cradles, puts its medical institutions, from medical publishing houses to hospitals and medical schools and cemeteries, on attractive display in a small paperback volume, published by SmithKline Corporation, parent company of Smith, Kline, and French Laboratories.

Almost all the institutions, in various areas of the city, are depicted in a color photograph, and their history is briefly given. It is interesting even to one who has only visited the city; it would be fascinating to one who had lived there.

Our thanks to SmithKline for the *gratis* copy of this contribution to the Bicentennial.

Harry L. Arnold, Jr., M.D.

Hawaii Academy of Family Physicians' Newsletter

J.I. Frederick Reppun, M.D.



The logo of our Bicentennial meeting in Boston 20-23 Sept.

NEWS OF MEMBERS—Harry Kramer has been elected to Life membership and **Howard Liljestrand** to Sustaining. **Ernesto Santos** of Wahiawa has been having a rough time with four attempts on his cervical spine by the surgeons. Invariably it is the doctors and nurses who develop complications, sensitivities and reactions! **Fred Dodge** is in hopes of making a trip to China (PRC), leaving 5 May, but there is many a slip between Mao and lip. **Don Hall** is transferring to San Francisco.

DINNER MEETINGS—for the edification of members and for the long projection, here is a tentative schedule of the dinner meetings in 1976:

26 June **21 August** **30 October**

The annual meeting comes in January 1977.

MEMBERSHIP—The latest from headquarters is that Hawaii has 115 members.

THE BOSTON MEETING—The House of Delegates meets on Saturday 18 September. The 28th Annual AAFP Scientific Session starts on Monday 20 September and goes through Thursday 23 September. It is followed immediately by the AAFP Invitational Scientific Congress in London, England, 23 to 30 September. Any member wishing to submit a resolution for the House needs to get it in before 18 August, preferably through the local chapter.

RE-ELECTION—All members except one (1) have been re-certified for another three years from 31 Dec. 75—those who were up for re-election, that is.

ANCIENT HISTORY—

30 years ago Dr. G. Practice Queen's Hospital
To: Mrs. A. C. Room 320 OBS

Hospital attendance, board and lodging 8 days @ $6	$ 48.00
Infant attendance, board and lodging 8 days @ $1.75	14.00
Operating Room (PPS)	25.00
Anesthesia	15.00
Delivery room charge	15.00
Radio for 5 days	1.00
Miscellaneous lab. drugs dressings & surcharge & photo	31.30
	$149.30



New Members



David P. Campbell
1292 Waianuenue Avenue
Hilo, Hawaii 96720
GENERAL SURGERY



Ben Lin Hom, M.D.
Queen's Medical Center
Honolulu, Hawaii 96808
PATHOLOGY



Clinical Pathologist's Easy Chair

FRANCIS FUKUNAGA, M.D.

Electron Microscopy

Electron microscopy, usually considered a research tool, can also be of great diagnostic value to the pathologist and clinician. It is essential for the diagnosis of certain renal diseases, of some tumors, and of some hematologic, gastroenterologic, virologic and metabolic diseases.[1]

The electron microscope can help establish the diagnosis early in the course of renal diseases such as idiopathic nephrotic syndrome, amyloid nephrosis, and early diffuse diabetic glomerulosclerosis.[2] Increased use of the electron microscope has revealed new pathologic lesions that allow improved diagnostic differentiation and a means of evaluating therapy. Some lesions, such as chronic progressive hereditary nephritis and nail-patella syndrome, may be diagnosed only with the electron microscope.

In the diagnosis of tumors, where light microscopy fails or is equivocal, the electron microscope has been valuable.[3] The absence of cell membrane specialization is characteristic of lymphoreticular tumors and is therefore helpful in differentiating anaplastic carcinomas from reticulum cell sarcoma.

Certain lesions have characteristic secretory granules, such as mucin granules in adenocarcinomas, lysosomal granules in prostatic carcinoma, and melanin granules in melanomas. There are also certain characteristic cytoplasmic organelles in some tumors. Some authors feel that the effects of chemotherapty can best be assessed by the ultrastructural study of the cell.[4]

The hematologist is finding increased use for electron microscopy. He is able to study the basic defects of erythrocytes in various anemias. Ultrastructural study of platelets is helpful in some platelet disorders. The electron miscroscope has been useful in distinguishing acute promyelocytic leukemia from other leukemias.

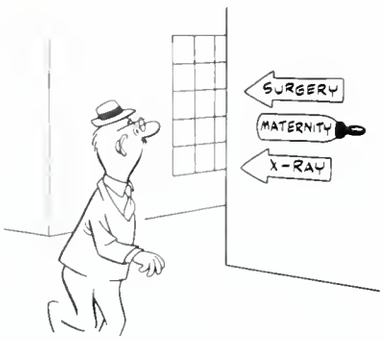
The gastroenterologist can see specific lesions that are important for the diagnosis of Whipple's disease, non-tropical sprue, and amyloidosis, by electron microscopy.

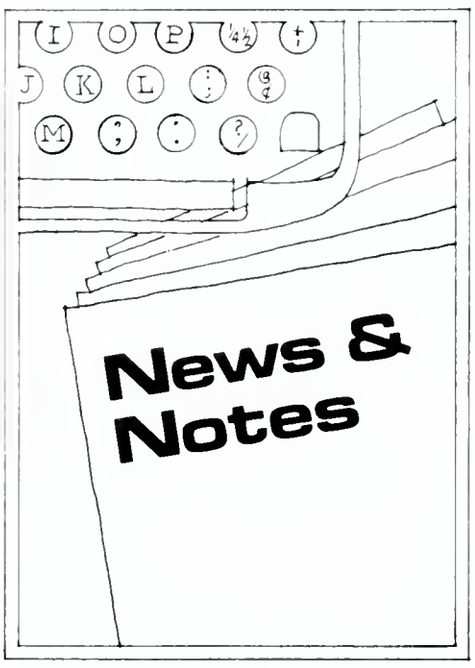
The electron microscope can establish the family to which a virus belongs and the use of viral antibody complexes will allow further definitive identification.

Some storage diseases, such as Fabry's disease, can be identified ultrastructurally. The study of peripheral capillaries in the late stages of diabetes mellitus provides a means of detecting widespread capillaropathy, the two most significant manifstations being retinopathy and nepropathy.[5]

REFERENCES:

1. Burns WA et al: The clinician's view of diagnostic electron microscopy, *Human Path* 6(4): 467-478, 1975.
2. Seymour AE, Spargo BH, Penksa R: Contributions of renal biopsy to the understanding of disease, *Am J Path* 65:550, 1971.
3. Rosai J, Rodrigues HA: Application of electron microscopy to the differentiatial diagnosis of tumors, *Am J Clin Path* 50:555, 1968.
4. Gyorkey F et al: the usefulness of electron microscopy in the diagnosis of human tumors, *Human Path* 6(4): 421-441, 1975.
5. Yodaiken RE, Pardo V: Diabetic capillaropathy, *Human Path* 6(4): 455-465, 1975.





HENRY N. YOKOYAMA, M.D.

Professional Moves

There was just a whisper of activity in the medical community during April, i.e. all except in Hilo . . . Pediatrician **Ruth Matsuura** and internist **Scott Miles** closed their offices for several days while relocating to Ka Waena Lapa-au (the newly completed medical building) at 670 Ponahawai, Hilo, Hawaii. Also in Hilo, internist **Djon Indra** associated with the Hilo Medical Group at 1292 Waianuenue Ave, while **Desmond Wong** announced that he was open for regular hours at 102 Kinoole Street . . . The only Honolulu announcement was that of ophthalmologist **Donald Sroat** opening his office at 332 Uluniu, Kailua . . . Maui internist-cardiologist **Robert Moser** was appointed executive vice-president designate of the American College of Physicians . . . Bob will join the ACP on a full-time basis next January . . .

We learned that Maria and **Roger Brault** will leave Hawaii in May, take a foreign missionary orientation course in Maryknoll, New York, and then off to the lonely outposts of the world for the next 3 years . . . (We envy them . . . And wish them bon voyage.)

Announcements

Morton Berk, organizing committee chairman reports that the VIth Asian Pacific Congress of Cardiology will be held at the Sheraton Waikiki, Oct 3rd to the 8th (7 am to 1 pm). Those interested should write to: VIth Asian-Pacific Cardiology Congress, 245 N. Kukui St., Honolulu 96817. Mort reports that 1,000 to 1,500 cardiologists from various countries will be attending this quardrennial congress. Previous congresses were in Manila (1956), Melbourne (1960), Kyoto (1964), Tel Aviv (1968) and Singapore (1972). Program chairman **Danelo Canete** is lining up an interesting format . . . (Approved for AMA credits and approval pending for AAFP credits.)

Annual HMA meeting to be held at Ilikai Oct 25 (Monday) to Oct 29 (Friday) . . . Scientific theme: "Global Medicine—Diseases of Travel" Activity schedule as follows:

Golf Tournament at Mid Pac CC Tues Oct 26 followed by "Sportsman's Night" same evening at Mid Pac CC with entertainment . . .

Banquet at Ilikai on Friday Oct 16. (Casual dress, no dancing . . . Entertainment by Frank Delima and group . . Frank is a Portugese "Zulu"—hilarious, entertaining, talented, with his own repertoire of locally oriented songs and jokes)

Tennis tournament: Chairman **Virgil Jobe** promises a fun event . . . a doubles round robin on 2 Sundays . . . perhaps even a draw-a-partner flight . . . beer, pretzels, and socializing . . . individual ability does not matter . . . for professionals and amateurs as well . . . anyone who can swing a tennis racket is eligible . . .

Fishing tournament: Chairman **Andy Morgan** plans the tournament in either August or September when the fish are biting and weather is good . . . guaranteed that no one will get sea sick . . . plenty of fish . . . no chumming predicted . . .

Skin Diving tournament: Chairman **Henry Yokoyama** . . . first weekend in September . . . limit 8 participants . . . first choice to previous participants . . .

Bow and Arrow tournament: Chairman **Bill Davis** . . . miss a deer at point blank range . . . lots of hiking . . . must be in condition . . .

Ping Pong tournament: Chairman **Franklin Young** . . . first tournament . . . most likely doubles matches. (At least one team member has to be a HMA member . . . the other partner may be a family member) . . . promises to be a lively, entertaining tournament . . .

HIGUCHI INSURANCE AGENCY, INC.

(808) 531-7091

HONOLULU COUNTY MEDICAL SOCIETY'S
INSURANCE PROGRAM ADMINISTRATOR

TERM LIFE INSURANCE
DISABILITY INCOME INSURANCE
MAJOR HOSPITAL INSURANCE
DEFENDANTS REIMBURSEMENT INSURANCE

Other possible tournaments: Marathon tournament chaired by **Jack Scaff** and a bicycle tournament chaired by **Jeff Sol** or **Dale Adams** . . .

Further information on Golf Tournament: HMA prexy **Bill Dang** promises a color TV set for overall low net from which he is automatically disqualified because he has to present a President's Trophy also for overall low net . . . Bill promises that perennial tournament winners **Al Paraz** and **Ernesto Orionion** will have honest handicaps . . . HMA executive secretary **Tom Thorson** will donate a Inter-County Team Low Net Aggregate Trophy (Teams to be predesignated by the county society presidents). Bill Dang feels that since the county society teams will represent different golf courses, the winning team should be hailed "The Intercourse Champs."

Life In These Parts

Our Editor, **Harry Arnold Jr.** appeared on the April 4 TV panel program, "Conversation" with Betty Smyser. Harry argued for restoration of the death penalty, not as retribution or punishment, but simply to remove dangerous people from society . . . He feels that the penalty could be administered quietly and without ceremony, by giving the condemned person a drink to induce sleep, and then an IV to induce death (i.e. in lieu of the gallows, the electric chair, the gas chamber or a firing squad). **Star-Bulletin** editor Bud Smyser invited his readers to "Speak Up" on whether they favored such "humane executions." Of those who responded, 22 favored Harry's proposal while 5 opposed the death penalty in any form . . . (As Bud Smyser commented, "Certainly death administered compassionately and without pain is quite a different thing from the ceremonial death we now associate with capital punishment.") (Food for thought.)

Our friend George Oakley was brain damaged in a 1968 auto accident. The $4.5 million suit against the county, state and the contractor was finally settled out of court for $200,000 . . . George was injured when his car went out of control 15 miles from Mauna Bay enroute to Waimea on an inadequately compacted highway . . .

Circuit Judge John C. Lanham ruled on April 5 that Queen's Medical Center must either give neurosurgeon **Maurice Silver** another hearing on his application for staff privileges, or grant those privileges. The Judge felt that the hospital's board of directors violated the doctor's rights to procedural due process when they denied his staff application in 1973. Maurice has waged a protracted legal battle since 1969 charging that the local hospitals have denied him privileges since 1962. The new trial is to begin in May . . .

Richard Smart, owner of Parker Ranch and chairman of the fund raising drive for the Waimea medical center (outpatient center) announced that the campaign exceeded its goal by 10%. The Lucy Henriques Medical Center fund drive raised over $500,000 which will supplement money from the Henriques estate that has grown in the last 44 years from $100,000 to $2.5 million.

Olaf Skinsnes, leprologist and John Burns Med School professor of pathology, last year successfully grew the leprosy bacillus under laboratory conditions. Olaf predicts that within the next 25 or 30 years, certain areas of the World will see the end of leprosy. He bases his prediction on statistics of new cases in Korea, Taiwan, Hong Kong and Japan which show the curve descending despite the fact that only 1/3 of all cases are treated. Olaf feels that modern drug therapy is accomplishing a "chemical segregation" of leprosy patients . . .

The nuclear medicine men of the major hospitals and clinics have established a radiopharmacy temporarily located at Kuakini Hospital. The chairman is **Richard Wasnick** and members of the board include **Robert Nordyke, Richard Littenberg, James Ball** and **Winfred Lee.** Dick says, "the exhorbitant cost of airmailing radioisotopes separately to each hospital compelled us to get together. The cost savings of centralized purchasing and dispensing are considerable."

The Kauai Health Department is posting warning signs on its North Shore after 4 cases of leptospirosis were discovered in the past 4 months . . . The first symptoms of leptospirosis are fever (of 102°), fatigue, headaches, chills, jaundice and vomiting . . . "Muscleaches of the thighs and lower back distinguishes leptospirosis from hepatitis . . ." (According to the Health Dept.)

Our dentists lobbied hard enough to get their Medicaid fee schedule increased last year, our physicians finally convinced the Legislature to allow full reimbursement for our usual and customary fees . . . The measure authorizes $2.3 million in State funds to be boosted by $1.7 million in Federal funds for the increased fee schedule. The program serves an estimated 86,000 persons each month and is expected to cost about $54.2 million this fiscal year.

Kona physician **James Mayer** returned from 3½ weeks in Guatemala where he worked with the February earthquake victims. Jim flew over 5 days after the initial earthquake as a volunteer sponsored by the Kuan Yin Foundation (a Canadian relief organization?). Jim who was also involved in the Saigon evacuation last April, observed that the situation in Guatemala contrasted with war devastated Vietnam in that most people were relatively well dressed and friendly, even in the most trying times . . . and there was no apparent hostility.

The Windward Oahu Cardiac Rehabilitation Program, held Monday, Wednesday and Friday mornings at 7:30 started with 12 members in April. **Mor McCarthy** is coordinator, **Dale Adams** program director, and **Jeffrey Sol** assistant director . . . The cost is $92.50 for the EKG and treadmill (most of which is covered by insurance) and $18 per week for the 12 week course. Mor indicates that after the 12 week program, individuals can move into YMCA programs or other jogging and running programs.

A corporation including Lihue physicians **Jeffrey Goodman, Thomas Grollman** and **Arnold Nurnock** are raising funds for a recompression chamber for Kauai. In

WILLIAMS MORTUARY

"CHAPEL OF THE CHIMES"

1076 S. Beretania St., Phone 537-2587 **Ample Parking Adjoining Mortuary**

OVER A CENTURY OF SERVICE

"Service measured not by gold but by the Golden Rule"

MEMBER

National Selected Morticians, National Funeral Directors Association,
Order of the Golden Rule, Hawaii Funeral Directors Association

1974-75, there were 13 cases of diving-related incidents in which the chamber could have been used. . . And there are an estimated 250 to 300 divers on Kauai . . .

Claude Caver's Repertoire

"I was in Kona last week and heard about a new disease going around town . . . The local boys were saying "No fool 'round hippie gals 'cuz you goin' get 'hippieitis' "

There's a new rock and roll group in town which works only 5 days a month . . . They're known as "The New Christy Menstruals."

Sportsmen

Among the 67 runners entered in the 6th Annual Norman K. Tamanaha Memorial Hawaiian Marathon on Maui in March were **John Withers, William James, Jim Harrison, Edwin Dierdorff, Howard Keller** and **Joe Cunningham . . .**

Kenneth Haling tied for 1st place in the Maui Chess Club's first tournament for 1976 held in March. **B. A. Weeks** and partner were 2nd in the monthly Master Point game of the Wailuku Bridge Club for March . . .

Odds & Ends

Census Bureau statistics for 1958 to 1972 reveal that women get ill oftener, but live longer than men. Women have 4 to 14% more acute conditions and are more likely to get infective, parasitic, respiratory and GI problems. Men have higher death rates from cerebrovascular diseases . . . By 1973 women had an average life span of 75.3 years as compared to 67.6 for men.

Gleaned from Donnelly's column: **"Jack Scaff,** pied piper of the Honolulu Marathon Clinic will marry Donna Tengan, fellow marathon runner on June 27 . . . The ceremony will be at sunrise on the slopes of Diamond Head and the guests include the entire Marathon Clinic of 1,000. Afterward, everyone will jog over to the Kapiolani Park Bandstand for the usual Sunday morning clinic and long distance run around Diamond Head and through Kahala."

Bill Gee, Associate Sports Editor *(Honolulu Star Bulletin)* wrote: "Friends of **Dr. Joseph Lam** are concerned on learning that he is seriously ill. 'Dr. Joe' looked after the health of thousands of patients when he was director of the medical clinic at Palama Settlement during the 1939's and later in private practice in the same neighborhood . . . He eased the pain of many a Palama athlete with compassion and skill—and never charged any of them a dime during the Depression years . . . They still remember . . . I was one of them . . ."

Princeville at Hanalei got the green light to reactivate a light aircraft landing strip on the eastside of Kauai . . . Mindful of environmental health concerns, Kauai district health officer **Robert Melton** reported the airstrip may cause 'noise nuisances and distraction' to automobile drivers and suggested pull-off areas for motorists, or placing warning signs . . .

Psychiatrist **Leonard Jacobs,** director of the Kalihi Palama Mental Health Center (who did sleep research at the National Institute of Mental Health) will be a co-leader in a couples group study on communication at Kaneohe YWCA starting in April (Guess some couples communicate better while sleeping) . . . **Robert Marvit** was moderator and luncheon speaker for a symposium on "The Mentally Ill Criminal Offender: A Community Concern" sponsored by the Mental Health Association of Hawaii on May 1 at the Hilo Lagoon Hotel . . . **Robert Kemble** discussed the role of the expert witness and deputy health director **Audrey Mertz** explained programming and facilities . . .

A 5 year study (1970-1975) of surgical services in the U.S. chaired by George Zuidema showed that of 93,000 physicians doing surgery in the U.S., only 50,000 are board certified . . . 15,000 are residents and interns in training and 30,000 are general practitioners or not board certified . . . George feels that the hospitals must start clamping down on who should be authorized to perform surgery . . . Since some physicians whose surgical privileges are cut off may sue the hospitals, he feels that legislation may be needed to protect hospitals . . .

The President's Council on Wage and Price Stability reported that monopoly-like control by physicians coupled with a passive role by patients purchasing medical care are helping push up health care costs . . . Health costs soared to $118.5 billion last year, 40% of which was paid by federal, state and local governments.

George Monlux, assistant chief of emergency services at Kaiser complained that he has been unable to obtain City paramedics for transfering critical patients to Queen's CCU when Kaiser's CCU was filled . . . In a blistering letter to **Thomas Chang,** acting City & County physician, George called the situation "intolerable" because "the dispatcher has the power to refuse transfers . . . The dispatcher's judgment overrides the physician's judgment . . . It's a physician's prerogative and shouldn't be made by individuals who have not even had specialized medical training . . ." Apparently this "intolerable situation" is created by private ambulance services which criticize the City & County ambulance service whenever it engages in transfer of patients rather than responding to emergencies . . . Sure enough, Larry Walters, president of Physician's Ambulance Service complained that "Dr. Chang has decided to allow City Paramedic units to respond to all urgent transfer calls from hospitals, though that policy has not yet gone into effect . . . This will put them (the City and County) in the private transfer business which knocks our business down the drain . . ." Meanwhile Tommy Chang caught in the middle of a ticklish situation said that he did not care to comment until he had studied the matter further . . .

It seems that Molokai has too few doctors and too many patients . . . The Molokai Community Action Program (MCAP) and the Molokai Clinic staff met recently to set up guidelines to cut down on the "congestion, confusion and frustration at the Clinic." **Paul Stevens,** Clinic director recommends "that the patients give themselves more than a cursory evaluation before seeking professional attention . . . that the community exercise more discretion in the use of the emergency room since that facility is not meant to be an after hours outpatient clinic . . . that since appointments tend to lessen congestion somewhat, the Clinic will start offering afternoon appointments on a trial basis . . ."

Ex-nurse, Rep **Faith Evans** (24th Dist. Windward Oahu) is for putting controls on health costs by establishing a Health Services Cost Review Commission to help bring costs under control . . . Such a Commission will review and approve or disapprove health care rates requested by all public and private hospitals and related institutions. Faith says, "I strongly believe that establishing such a review procedure would eliminate 'scapegoating' such as occurred during the recent nurses' strike. As it is now, hospitals may automatically increase room rates and place the blame directly on wage demands of workers, construction costs, malpractice insurance rates, or whatever the convenient excuse of the moment."

When the State Mental Health Law was declared unconstitutional by Federal Judge Sam King, the legislature considered a new law . . . (But Maui was agin' it). **Alfred Arensdorf** of the Maui Psychiatric Association and **E. H. Auerswald,** Chief of the Maui Mental Health Center testified before the State Legislature that there was no need for a new mental health law. E. H. said a mental health law would mean commitment of a dangerous person to a hospital but since Maui's facility is located in a pediatrics ward and the security rooms have no bathroom facilities, all such patients would have to be sent to Honolulu . . .

EST (Erhard Seminars Training) has its advocates . . . **Geoffrey Galbraith,** chairman of the EST board in Hawaii said that in his est training he was able to stop judging people. "I thought that I evaluated people because I wanted to have an

advantage over them. In the training I found out that what I wanted . . . was for people to love me . . . I was able to just let go of the tremendous amount of internal pressure to be better than people, because I noticed I didn't want to be better than people."

Byron Eliashoff, also on est's advisory board said that trying to classify est left him in confusion at first when he took est 3 years ago, but he finally concluded est is not psychology. "Really, to me it is education in the truest sense. Psychotherapy is primarily rehabilitative . . . EST takes people at their normalcy and gives them new points of view to allow them to develop further. They take their own abilities and expand them further. That's what education is all about." Byron also added, "I became aware of how a person could influence his own physical reactions . . . I began to study biofeedback and am pursuing it in my practice."

UH med school dean **Terence Rogers** commented, "From my own experience and that reported by others close to me, the impact of est training might be no more profound than that to be expected from four solid days of uninterrupted self examination under any circumstances . . . I for one would not be capable of that kind of discipline without voluntarily entering into a structured educational exerience . . ."

Miscellany

A senior citizen and his new young bride registered in a Miami honeymoon suite . . . Next morning, the spry oldster was up at the crack of dawn, downed a hefty breakfast and went out for his morning constitution . . . Several hours later, a bedraggled bride looking as if she had not slept a wink came down to the dining room and ordered coffee only . . . The curious waiter asked sympathetically, "You must have had a rough night?" The bride complained, "Listen, before we got married, he said he'd been saving up for 40 years . . . And I thought he meant money!" (**Bill Moore** read this joke in Human Sexuality)

Oncology Dialogue

A 59 year old man had an abdominal perineal resection for adenocarcinoma of the rectum, Duke's C with regional nodes involved . . . Moderator **Noboru Oishi** turned to radiotherapist **Ed Quinlan,** "Ed, would you comment on the role of radiotherapy?" Ed: "Postop radiotherapy will prevent local recurrence in the perineum, but will not prevent distal metastasis e.g. to the liver etc. . . . The status of preop and postop radiotherapy is somewhat in limbo at present . . ." Noboru queried further: "Wasn't there some study involving preop radiation with 2500 rads?" Fellow radiotherapist **Carl Boyer** said frankly: "That's a study to show that radiotherapy was no good . . . One of the problems with preop radiotherapy is that it looks so good that the surgeon does an anterior resection and it ends disastrously . . . We know that we can sterilize these tumors and prevent local recurrence with larger doses . . ." Noboru: "How soon can you tell about the success of radiotherapy?" Carl: "You should be able to tell in a month after 4000 to 4500 rads . . ." Pathologist **Grant Stemmerman:** There is correlation with the maturity of the tumor . . . Those that are well differentiated do better." Noboru: What's the status of CEA? Stemmy mumbled something non-committal . . . Noboru added, "I still think it should be done, but people are becoming discouraged . . ." Surgeon **Choon Kia Yeo** asked about the status of postop radiotherapy . . . Ed Quinlan commented: "With distal rectal lesions below 7 cm, there is a 25% 5 year recurrence. Postop radiotherapy is more difficult . . . The dose is higher and cases show more desquamation . . ." Surgeon **Henry Oyama** added: "If preop radiation is given, then the surgeon is committed to an A-P resection . . ." Noboru was pessimistic: "Duke's C lesions of the rectum have a 5 year survival of 5% and are worse that Duke's C of the colon . . ."

A 50 year old Japanese male, a 2 pack smoker, was admitted with a 1 month history of cough, SOB and Lt chest pain. Chest Xrays showed a Lt pleural effusion and possible tumor. Cell blocks showed squamous cell carcinoma . . . Moderator **Noboru Oishi** went probing: "How about a needle biopsy for futher confirmation before surgery?" Surgeon **Glenn Kokame** was aghast and adamant: "Hell! Do an open biopsy and get a big enough piece." Pathologist **Grant Stemmerman** chuckled gratefully . . .

Surgical Conference

A 72 year old Japanese woman with a long history of lower abdominal pain neither caused or relieved by food had seen many physicians and had many repeated radiographic and endoscopic studies. She was down to 58 lbs from 77 lbs and had taken anti-arthritic medication for many years . . . A recent GB series did not visualize, but an IV cholangiogram showed a normal common duct, but a nonvisualizing cystic duct. The preop diagnoses were: "Cholelithiasis; possible superior mesenteric artery syndrome . . ." At surgery a choledochoduodenostomy was performed . . . The discussion centered around that nebulous entity "Superior Mesenteric Artery Syndrome" . . . The resident quoted Harrison's saying that it was questionable whether such a syndrome actually existed and that the syndrome includes postprandial pain and weight loss . . . **Clarence Hodges,** director of surgical education stated: "I've seen only one case . . . But I have to begin with the comment that this diagnosis is overdone and I've seen some tragic results . . . The case I saw was a Vietnam veteran with orthopedic problems and weight loss. He was vomiting and having more weight loss and was relieved by a duodenojejunostomy . . . Weight loss is the most important clinical picture. With non-descriptive postprandial fullness and no weight loss, be careful with this diagnosis . . ." Neurosurgeon **Max Urata** contributed: "I've seen only one classic case with complete obstruction during training . . . We just flipped him over on the ortho frame after feeding and he did well . . ." Radiologist **Don Ikeda** in discussing the preop upper GI series was explicit: "I would vehemently deny the existence of this syndrome . . ." When the surgical resident piped, "The second part of the duodenum was dilated about 1½ times normal at surgery," Don quipped, "Was someone leaning on the duodenum?"

Our "Angels"

	Page
American Security Bank	134
Higuchi Insurance Agency, Inc.	152
Eli Lilly and Company	
Darvocet/Darvon	138
Nalfon	142
McNeil Laboratories, Inc.	
Tylenol	156
Pharmaceutical Manufacturers Association	136, 137
A.H. Robbins	
Allbee/Donnatal	147, 148
Roche Laboratories	
Valium	132, 133
Williams Mortuary	153

A NON-ASPIRIN ALTERNATIVE TO COMPOUND ANALGESICS

Documented potency: Double-blind clinical studies[1,2,3] demonstrate the efficacy of TYLENOL® acetaminophen Extra-Strength capsules (500 mg.) in the control of moderate to severe pain.†

No aspirin side effects: Unlike most compound analgesics, TYLENOL Extra-Strength capsules contain no aspirin; they therefore minimize the risk of side effects often associated with aspirin, such as gastric irritation, hemostatic disturbances and allergic reactions.

So when your patients with minor conditions need greater analgesic strength than that provided by regular doses of the mild analgesic products, recommend or prescribe TYLENOL Extra-Strength capsules.

1. Hopkinson, J.H. III, et al.: Curr. Ther. Res. *16*:194 (Mar.) 1974.
2. Berry, F.N., et al.: Curr. Ther. Res. *17*:361 (Apr.) 1975.
3. Smith, M.T., et al.: Curr. Ther. Res. *17*:452 (May) 1975.

Precautions and Adverse Reactions: If a rare sensitivity reaction occurs, the drug should be stopped. TYLENOL® acetaminophen products have rarely been found to produce any side effects.

Available in bottles of 50.

†Episiotomy was used as a model to evaluate analgesia.

Recommend or prescribe 2 caps t.i.d. or q.i.d.*

*No more than a total of 8 capsules in any 24-hour period.

© McN 1976

McNEIL McNeil Laboratories, Inc., Fort Washington, Pa. 19034

TYLENOL® acetaminophen EXTRA-STRENGTH CAPSULES 500 mg.



JUNE, 1976
VOL. 35, NO. 6

Hawaii Medical Journal

CONTENTS

Firecracker Smoke is not an Allergen 165
Carl W. Lehman, M.D.

Anti-Spermatozoal Antibodies in Infertile Couples 166
Susumu Yamauchi, R.T. and Gail Li, M.D.

Continuing Medical Education 174

Editorials 173

Hawaii Academy of Family Physicians' Newsletter 178

HMA Council Meeting 175

HMA Newsletter 171

Index to Volume 33 185

Letters to the Editor 161

New Members 173

News & Notes 179

President's Message 171

Acquisitions Division SP
University of California, San
Francisco
San Francisco California 94143

LIBRARY
U.C. SAN FRANCISCO
JUL 26 1976

Both often



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium®
(diazepam) Ⓡ IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc
Nutley, New Jersey 07110

We're the only lab in the islands affiliated with Bio-Science.

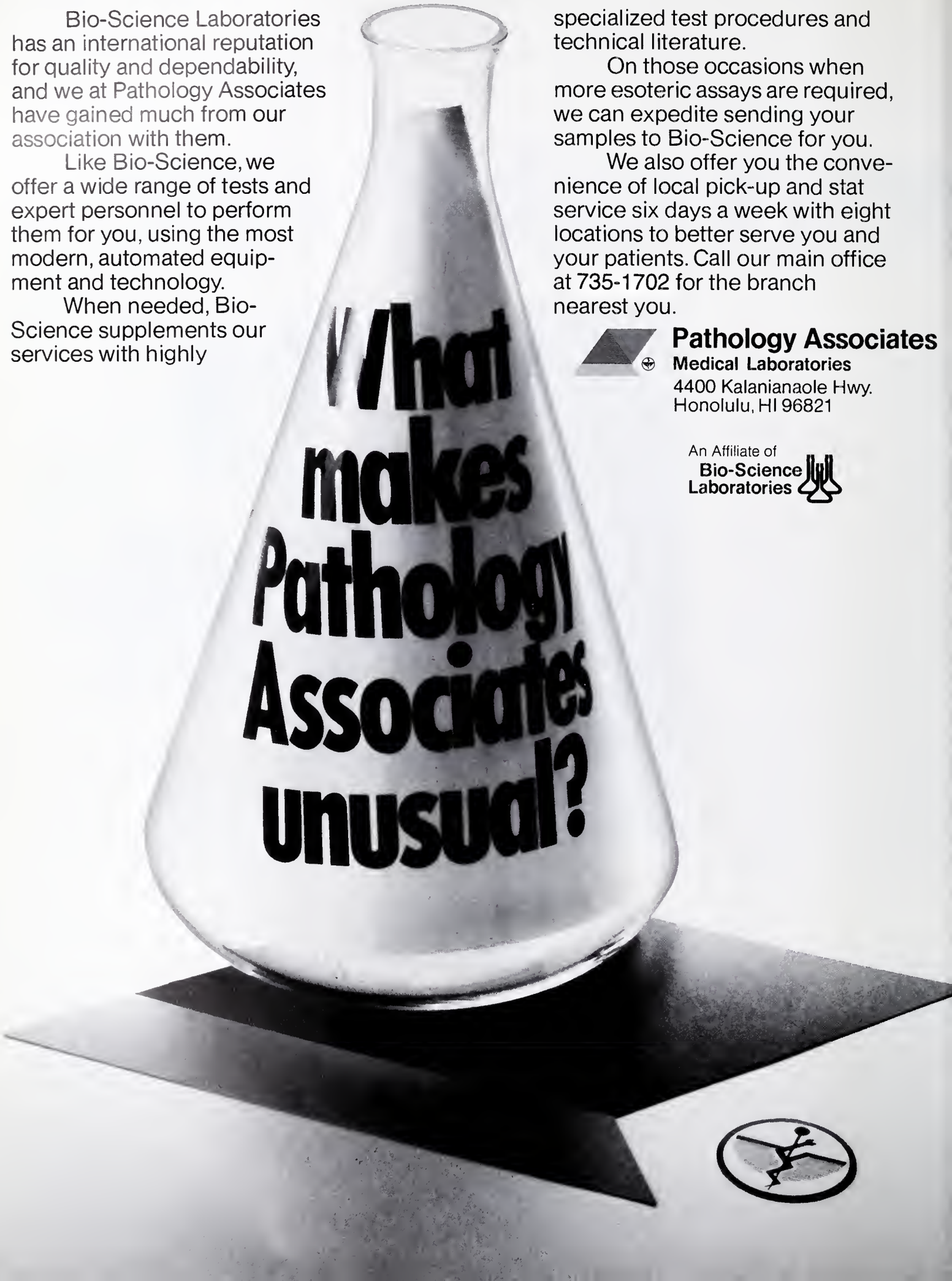
Bio-Science Laboratories has an international reputation for quality and dependability, and we at Pathology Associates have gained much from our association with them.

Like Bio-Science, we offer a wide range of tests and expert personnel to perform them for you, using the most modern, automated equipment and technology.

When needed, Bio-Science supplements our services with highly specialized test procedures and technical literature.

On those occasions when more esoteric assays are required, we can expedite sending your samples to Bio-Science for you.

We also offer you the convenience of local pick-up and stat service six days a week with eight locations to better serve you and your patients. Call our main office at 735-1702 for the branch nearest you.



Pathology Associates
Medical Laboratories
4400 Kalanianaole Hwy.
Honolulu, HI 96821

An Affiliate of
Bio-Science Laboratories

Hawaii Medical Journal

Published Monthly by the
HAWAII MEDICAL ASSOCIATION
(Incorporated in 1856 under the Monarchy)
510 S. Beretania St., Honolulu, Hawaii 96813

EDITORS

Editor, HARRY L. ARNOLD, JR., M.D.
News Editor, HENRY N. YOKOYAMA, M.D.
Assistant Editor, DORIS R. JASINSKI, M.D., M.P.H.
Contributing Editor, ROBERT H. MOSER, M.D.
Contributing Editor, J.I. FREDERICK REPPUN, M.D.
Book Review Editor, WINFRED Y. LEE, M.D.
Executive Editor, PAUL STEWARD

OFFICERS

President, WILLIAM W.L. DANG, M.D.
President-Elect, CALVIN C.J. SIA, M.D.
Past President, WINFRED Y. LEE, M.D.
Secretary, R. VARIAN SLOAN, M.D.
Treasurer, GROVER H. BATTEN, M.D.

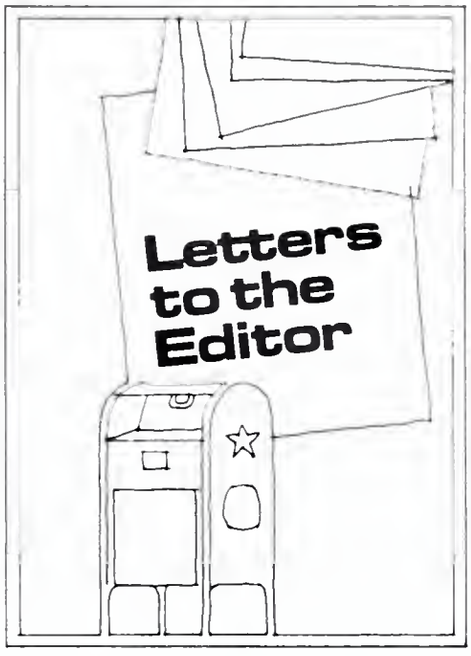
County Presidents

Hawaii, KENNETH HUGHES, M.D.
Honolulu, DOUGLAS B. BELL, II, M.D.
Kauai RIEAZI REMITIO, M.D.
Maui, CLIFFORD MORAN, M.D.
Delegate to AMA, GEORGE H. MILLS, M.D.
Alternate Delegate to AMA,
HERBERT Y.H. CHINN, M.D.

Advertising Representatives
National:
HAWAII MEDICAL ASSOCIATION
510 S. BERETANIA STREET
Honolulu, Hawaii 96813
Phone (808) 536-7702
Honolulu:
LILITH JURRY, Phone 946-0053

THE JOURNAL may not be held responsible for opinions expressed in papers, discussions, communications, or advertisements. The advertising policy of the HAWAII MEDICAL JOURNAL is governed by the rules of the Council on Drugs of the American Medical Association. The right is reserved to reject material submitted for editorial or advertising columns. All material for publication must be in the hands of the editor on or before the 10th day of the month preceding publication date. Reprints of original articles will be supplied at actual cost. A reasonable number of illustrations accompanying an article will be accepted for printing. The right is reserved to ask the author to bear cost of these when it is found necessary to do so.

Copyright, 1976 by the Hawaii Medical Association, Honolulu, Hawaii. 2nd class postage paid at Honolulu, Hawaii. Office of Publication: Mabel L. Smyth Memorial Building, 510 S. Beretania St., Honolulu, Hawaii 96813.



President
Hawaii Medical Association
510 S. Beretania Street
Honolulu, Hawaii 96813

Dear Sir:

After due consideration, I have decided to resign from the Hawaii Medical Association, the Hawaii County Medical Association and the American Medical Association. I am pursuing this action for the following reasons:

I am resigning from the AMA because of its policy of compulsary [sic] rather than voluntary membership. I was deeply disturbed by the way this issue was brought before the membership last fall; rather than present it openly it was pushed through at a meeting where there was no prior announcement that it would be brought up, where there was inadequate time for discussion and where the only speaker on it on the agenda was an AMA PR man. It is certainly highly ironic that the AMA which strongly supports freedom of choice for patients and opposes government compulsion in the delivery of medical care, this very AMA refuses to give doctors freedom of choice as to what medical societies they want to join.

I am resigning from the Hawaii Medical Association because of the Dang plan. I consider this plan an insult to the physicians on the outer islands. I do not think that we should be forced to contribute towards a building that is primarily for the Honolulu physicians, however, I think that at the very least this contribution should have been made voluntary rather than compulsary.[sic].

I am resigning from the HCMA because it is essentially a useless organization to the Kona physicians. The county society has been almost totally insensitive to the needs and problems of Kona doctors. It has been extremly reluctant to do peer review of a serious ethical problem in this area, it has been unnecessarily critical of the Kona physicians when we tried to resolve our own problems, it refuses to discipline an irregular practicioner [sic] and it has refused to hold more than one meeting a year in Kona in spite of repeated requests and the fact that we represent more than one fourth of the island's physicians.

I feel that these are all issues that need full and open discussion so I am sending a copy of this letter to the editor of the State journal for publication.

ALLAN S. HUBACKER, M.D.

The AMA does not and could not make membership in itself compulsory; this is up to each state medical society. "Unified" membership was voted upon by the Hawaii State Medical Association House of Delegates, after prior announcement (to them) was made, and it is to them that any complaints should be made. They also adopted the "Dang Plan."–**Ed.**



Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct nontherapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

P-M-A
Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005

One contains aspirin.
One doesn't.



Darvocet-N® 100
100 mg. propoxyphene napsylate
and 650 mg. acetaminophen

Darvon® Compound-65
65 mg. propoxyphene hydrochloride,
227 mg. aspirin, 162 mg. phenacetin,
and 32.4 mg. caffeine

Lilly

Additional information available to the profession on request.
Eli Lilly and Company, Inc., Indianapolis, Indiana 46206

500341

New Year's asthma is from irritation, not allergy. . .

Firecracker Smoke is not an Allergen

CARL W. LEHMAN, M.D., *Honolulu*

● *Intracutaneous test of an extract of firecracker smoke compared with an air extract control manifested no difference in response between the two extracts. When patients' allergic symptoms are aggravated by exposure to firecracker smoke, this pollutant probably acts as an irritant rather than an allergic agent.*

The extensive use of firecrackers in Honolulu to celebrate New Year's Eve has led to a dense cloud of smoke which hovers over the city for variable periods of time, depending on weather conditions. Many asthmatic patients dread the exposure to firecracker smoke and report provocation of symptoms with exposure.

The author has been able to demonstrate that smoke from burning sugar cane is an allergic agent.[1] That extract was obtained by pumping the smoky air through Coca-glycerine extracting solution. The following is a study of the allergenicity of firecracker smoke.

Methods and Materials

An extract of firecracker smoke was prepared by pumping the smoky air with a De Vilbiss air pump for 24 hours through a solution containing equal parts of modified Coca's solution and 99% vegetable glycerine obtained from Colgate-Palmolive Co. During part of this 24-hour period, the air was sufficiently polluted with firecracker smoke to reduce visibility to one or two car lengths while driving.

As a control, an air extract was prepared during a 24-hour period prior to New Year's Eve. This was prepared by pumping outdoor air at the same setting for the same duration of time through the same type of extracting fluid.

The extracts were processed by filtering through a Seitz filter. They were cultured for bacteria and found to be sterile. Each extract was serially diluted 1:5 using sterile normal saline solution. Serial dilutions of both glycerine and phenol were made. The amount of glycerine in the #1 dilution of glycerine was equal to the amount of glycerine in the #1 dilution of each of test extracts.[2]

The study group consisted of allergy patients who were scheduled for intracutaneous testing with inhalant antigens. In my clinical judgment, their histories were consistent with allergic disease and significantly bothersome to each patient to warrant such testing and hyposensitization therapy.

Forty-one patients were studied. In the history, each patient was asked if exposure to firecracker smoke aggravated his allergic symptoms.

The patients were tested intracutaneously using weak dilutions of the extracts as well as the phenol and glycerine solutions as controls. Sufficient material was injected intracutaneously to produce a 4 mm wheal; after ten minutes the wheal was observed. If the wheal increased in size to 6 mm or greater, the reaction was considered positive. The weakest dilution which gives a positive reaction is the endpoint of reaction. If a positive wheal reaction occurs on the same dilution of the extract as to either phenol or glycerine, the reaction is considered to be negative. The results are tabulated in Table 1.

Results and Discussion

From Table 1, one can readily see that the whealing response to intracutaneous tests of the extract of firecracker smoke was identical to the air extract control. The fact that both extracts were more reactive than the comparable dilutions of phenol or glycerine indicates that allergenic material from the air was absorbed into the extracting fluid and that 32 out of 41 patients reacted with positive whealing responses. If firecracker smoke contains an allergenic material, it must be insoluble in modified Coca-

Department of Allergy & Clinical Immunology, Straub Clinic & Hospital, Inc., 888 S. King Street, Honolulu, Hawaii 96813.
Accepted for publication July 25, 1975.

TABLE I — *Whealing Reactions to Both Firecracker Smoke Extracts and Air Extract Control*

		More Reactive Than Glycerine Or Penol	Less Reactive Than Glycerine Or Phenol
Symptoms Aggravated When Exposed to Firecracker Smoke	Firecracker Smoke Extract	16	6
	Air Extract Control	16	6
Symptoms Not Aggravated When Exposed To Firecracker Smoke	Firecracker Smoke Extract	16	3
	Air Extract Control	16	3

glycerine solution, and thus detection is prevented in the method of intracutaneous testing with serially diluted extracts as used in this study.

Allergic patients who notice aggravation of their symptoms when exposed to firecracker smoke are probably experiencing an alteration of their threshold of tolerance to other allergens due to the irritant effect of the firecracker smoke. It is unlikely that an allergen is present in firecracker smoke.

REFERENCES

1. Lehman CW: Sugar cane smoke, an allergenic agent. *H Med J* in prep.
2. Rinkel HJ: The Preparation of Solutions, the Making of Dilutions, and Syringe Technique. *Arch Otolaryngology*, 77:64-77, January, 1963.

Antibodies and Infertility . . .

Anti-Spermatozoal Antibodies in Infertile Couples

SUSUMU YAMAUCHI, R.T. *and* GAIL LI, M.D., *Honolulu*

● *The causes of infertility are numerous; in many cases, the etiology remains undetermined. Mechanisms involving one or more immune phenomena may be involved.*

Antibodies against homologous spermatozoa have been described recently in the sera of infertile patients, by means of hemagglutination reactions, and by gross or microscopic spermatozoal agglutination.[1,2]

Another useful method for studying the same phenomenon is the immunofluorescent technique (IFT) on methanol-fixed smears of sperm.[3] Hjort et al have shown correlation between the condition of oligospermia, and four different type-specific, immunofluorescent staining patterns in an anti-spermatozoa antibody test (ASPA). This indicates the involvement of several different antigen-antibody systems.

Localized staining of the acrosome,[4] the entire head,[4,5] the posterior portion of the head,[4] the neck region,[6] the mid-piece,[4,5] and the tail, have been reported by other investigators.

The following study was undertaken to identify antibody systems to spermatozoa present in both male and female sera, and, further, to correlate these with staining patterns of spermatozoa observed by indirect immunofluorescence. Correlation of such anti-spermatozoal antibodies with the conditions of oligospermia and infertility, when present, were also determined.

In addition to a basic semen analysis and the indirect immunofluorescence studies mentioned above, the sera of both partners were tested for rheumatoid factor (RF), thyroglobulin antibodies (TA), anti-nuclear antibodies (ANA), anti-parietal cell antibodies (APA), anti-smooth

Kuakini Medical Center
Honolulu, Hawaii 96817

Accepted for publication July 28, 1975

muscle antibodies (ASA), and anti-mytochondrial antibodies (AMA).

Hepatitis-associated antigen (HAA, Australian Ag) and its antibody (anti-HAA) were also determined, because of the substantial percentage of hepatitis patients having a positive HAA titre. Furthermore, about 80% of hepatitis patients can be shown to have a positive ASA titre.[9,10,11] Approximately 90% of patients with primary biliary cirrhosis can be shown to posses positive AMA titres.[11,12]

Strong circumstantial evidence indicates infectious hepatitis and perhaps other liver diseases as significant causes of sterility. Robertson et al reported a lowered birth rate and a disturbed sex ratio amongst the newborn babies (ie, a pronounced deficit in male births), following a severe outbreak of infectious hepatitis in the town of Brigg, Lincolnshire, England.[13]

Materials and Methods

Twenty-one infertile couples were referred for study by a practicing obstetrician-gynecologist with an interest in fertility problems.

Fresh semen, obtained by masturbation, was subjected to a standard analysis within 2 hours of collection: calculation of total volume, sperm count, the ration of motile to immotile sperm, and sperm morphology.[8] Serum samples were obtained from both partners at the time the semen specimens were brought to the laboratory.

Anti-spermatozoal antibody (ASPA) was determined by the indirect immunofluorescence method of Hjort et al.,[3] referred to above. Methanol-fixed smears of spermatozoa were incubated with sera from husband and wife: following this, they were stained with FITC-conjugated goat antiserum to human immunoglobulins.*

As described by Roitt and Doniach,[14] ANA,[15] APA,[14] AMA,[11,16] and ASA[11,16] were determined with serum dilutions, respectively, of 1:10, 1:10, 1:16, and 1:20. Immunofluorescent staining was done by the indirect method. TA** and RF** were detected by using commercially available test kits. HAA and anti-HAA were determined by the technique of counterimmunoelectrophoresis in 1% Noble's Agar in Veronal buffer $\mu=0.05$, pH=8.4, for 90 min., at 200 V., and 30 mA. (17). Positive control sera were obtained from the Div. Biol. Stds., British Medical Research Council.***

Results

Results of the immunological tests for anti-spermatozoal antibodies were determined for each of the 21 couples and are presented in Table 1, with a description of the staining pattern where the ASPA test was positive. Table 2 presents the results of the staining patterns and semen analysis of the 21 men. Figure 1 shows photomicrographs of the different types of staining patterns obtained in both patients with spermatozoa of normal appearance and in patients with oligospermia and abnormally-appearing sperm.

Discussion

The indirect immunofluorescent ASPA test gives excellent and clearly distinguishable localized immunofluorescent patterns. These include: a) staining of the acrosome, b) staining of the equatorial segment, c) staining of the post-nuclear area, d) staining of the tail and e) staining of the entire head. These different patterns were readily distinguishable from each other, and almost certainly represent unique antigen-antibody systems.[3]

Using an identical test, Feltkamp et al., reported a variety of staining patterns in 34 of 77 infertile men, and correlated these with the serum spermatozoal agglutination test.[4] Haensch, on the other hand, in a large population of fertile men found positive ASPA tests in 74 of 1340 subjects tested.[18]

In the present study, low ASPA levels (titers $\leq$1:16) were detected in sera of various control groups. These control groups included pregnant women, children, and normal blood bank donors. Titers $\geq$1:16, however, were significantly more frequent in a test group comprised of infertile men. Post-nuclear staining was the pattern observed most infrequently in all groups; this staining pattern has not as yet been noted to occur in the sera of pregnant women or of children.[3]

In the present series of 21 infertile couples, two oligospermic men had positive post-nuclear staining patterns, as shown in Figure 1d. Another two infertile oligospermic men from the same series showed positive acrosomal staining patterns, as shown in Figure 1b. Semen analyses of these four cases showed remarkable oligospermia, definite motility dysfunction, and conspicuous morphologic deformities, as shown in Table 2 and Figure 1f. The 12 positive ASPA titers found in the present series represented seven men and five women; these titers ranged from 1:16 to 1:64. The positive results for the RF, TA, ANA, and APA, seen in Table 1, were generally of low titer. Because low titers for these serum autoantibodies are not uncommon in apparently healthy subjects,[19] these results are not of themselves necessarily significant. They are included here merely for the sake of completeness.

The positive ASA and AMA titers shown in Table 1 were significantly higher, ranging from

*Hyland Labs., Costa Mesa, Calif. 92626
**Wellcome Labs., Beckenham, Eng.
***Mill Hill, London NW 7 1 AA

TABLE 1.—*Results of autoantibody tests, HAA and anti-HAA, ASPA, staining patterns and diagrams by semen analysis.*

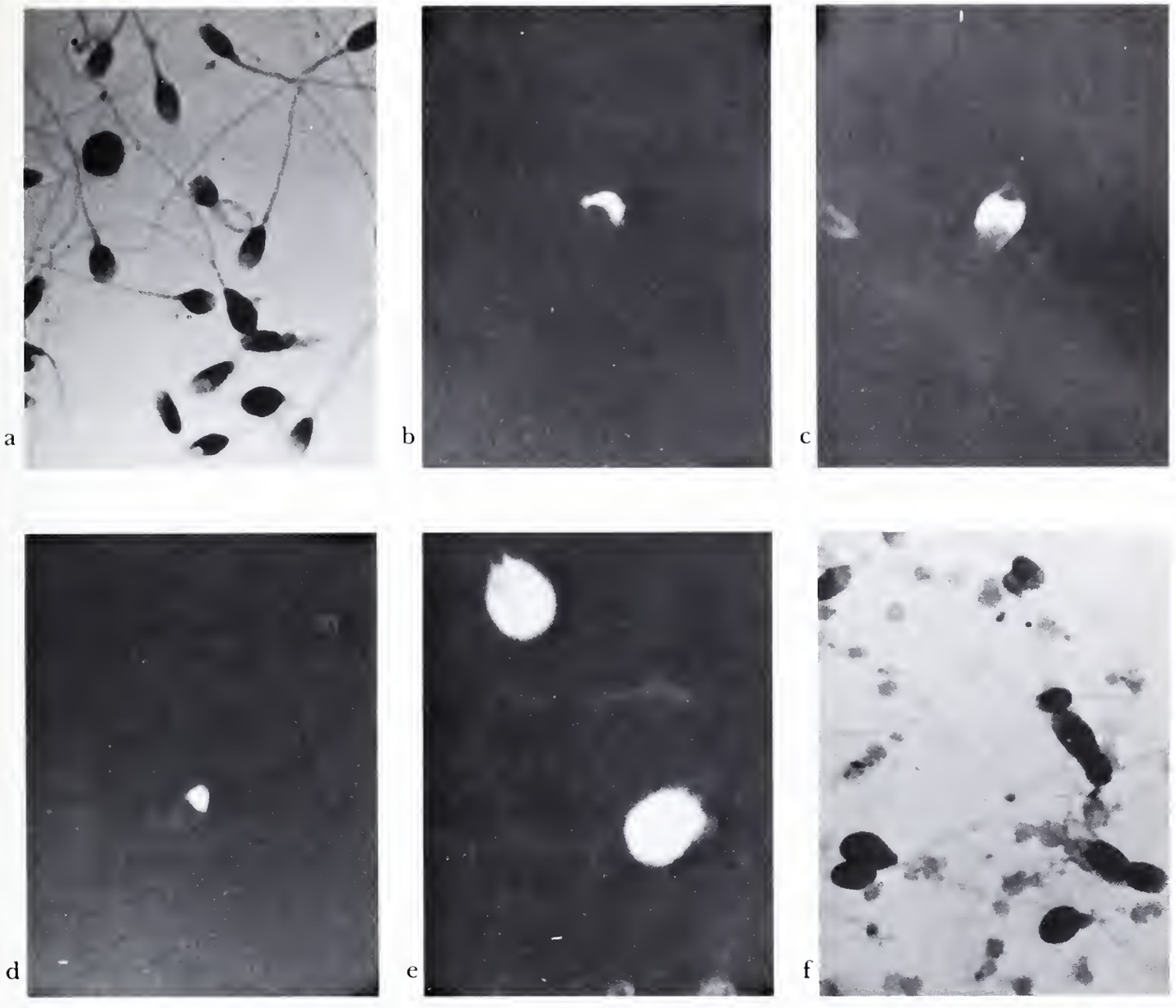
CASE NO.	SEX	RF	TG	ANA	APA	ASA	AMA	HAA	ANTI-HAA	ASPA	STAINING PATTERNS	DIAGNOSIS BY SEMEN ANALYSIS
1	M	–	–	–	–	–	–	–	–	–		normal
	F	–	–	–	–	–	–	–	–	–		
2	M	+	–	–	–	+	+	–	+	+	Post-nuclear	oligo-spermia
	F	–	–	–	–	–	–	–	–	–		
3	M	–	–	–	–	–	–	–	–	–	–	normal
	F	+	–	–	–	+	+	–	–	+	Acrosome	
4	M	–	–	–	–	–	–	–	–	–		normal
	F	–	–	–	–	+	–	–	–	–		
5	M	–	–	–	+	–	–	–	–	–		normal
	F	–	–	–	–	–	–	–	–	–		
6	M	–	–	–	–	+	+	–	–	+	Post-nuclear	oligo-spermia
	F	–	–	–	+	–	–	–	–	–		
7	M	–	–	–	–	–	–	–	–	–		normal
	F	+	–	–	–	–	–	–	–	–		
8	M	–	–	–	–	+	+	–	–	+	Acrosome	oligo-spermia
	F	+	–	–	–	+	–	–	–	–		
9	M	+	–	–	–	+	+	–	–	+	Equatorial	normal
	F	–	–	–	–	–	–	–	–	–		
10	M	–	–	–	–	–	–	–	–	–		normal
	F	–	–	–	–	–	–	–	–	–		
11	M	–	–	–	–	–	–	–	–	–	–	normal
	F	–	–	–	–	–	–	–	–	+	Entire head	
12	M	–	+	–	–	–	–	–	–	–	–	normal
	F	–	–	–	–	–	–	–	–	+	Acrosome	
13	M	–	–	–	–	–	–	–	–	–		normal
	F	+	–	–	–	–	–	–	–	–		
14	M	–	–	–	–	+	+	–	–	+	Entire head	normal
	F	–	–	–	–	–	–	–	–	–		
15	M	–	–	–	–	–	–	–	–	–		normal
	F	–	–	–	+	–	–	–	–	–		
16	M	–	–	–	–	+	–	–	–	+	Acrosome	normal
	F	–	–	–	–	–	–	–	–	–		
17	M	–	–	–	–	–	–	–	–	–	–	normal
	F	+	–	–	–	–	–	–	–	+	Equatorial	
18	M	–	–	–	–	–	–	–	–	–		normal
	F	–	–	–	–	–	–	–	–	–		
19	M	–	–	–	–	–	–	–	–	–		normal
	F	+	–	–	–	–	–	–	–	–		
20	M	–	–	–	–	+	+	–	+	+	Acrosome	oligo-spermia
	F	–	–	–	–	–	–	–	–	+	Acrosome	
21	M	–	–	–	–	–	–	–	–	–		normal
	F	–	–	–	–	–	–	–	–	–		

TABLE 2—*Comparison of immunofluorescent staining patterns of 7 males with positive anti-spermatozoa antibody reactions and semen analysis.*

STAINED STRUCTURE IN THE SPERMATOZOA	POSITIVE REACTION TO SERUM OF MALE	VOLUME (ml)	COUNT (X10⁶/ml)	MOTILE (%)	MORPHOLOGY (%)*
Front part of the acrosome	3/21	1-8	35-110	60-90	60-80
Equatorial segment	1/21	4.5	80	90	90
Post-nuclear region	2/21	3-5	30-50	40-50	40-60
Tail	0/21	ND**	ND**	ND**	ND**
The entire head	1/21	3.0	85	80	80
	Normal Values	2-6	>50	>80	>80

*Morphology: % Deformity, small, large, bicephalic, tapering, immature.
**ND=Not Done

FIG. 1.—*Photomicrographs of spermatozoa showing the Giemsa stains and immunofluorescent reaction to serum of men in 21 infertile couples.*



a) Normal spermatozoa by Giemsa stain (X1000)
b) Staining of the acrosome (X1000)
c) Staining of the equatorial segment (X1000)
d) Staining of the post-nuclear (X1000)
e) Staining of the entire head (X2000)
f) Deformity in oligospermia by Giemsa stain (X1000)

1:16 to 1:128. Of the 10 positive ASA sera, eight were positive for ASPA, representing the sera of seven men and one woman. All seven positive AMA sera were also positive for ASPA; these represented the sera of six men and one woman.

Anti-HAA accompanied by oligospermia and marked morphological deformities were detected in the sera of two men, and were also positive for ASPA, ASA and AMA. HAA or its antibody were detected in none of the above samples.

Despite the small number of patients in the present series, no new direct evidence has emerged suggesting that oligospermia, positive ASPA reaction and sterility in men may be induced by antecedent infectious hepatitis. The present data likewise do not point to previous overt or subclinical myxoviral or other infective orchitis as initiators of abnormal spermatogenesis. Such illnesses could, however, initiate antispermatozoal antibodies, and even some degree of testicular dysgenesis, dystrophy and/or atrophy,[20] which could result in the formation of abnormal sperm such as those seen in the present study. A retrospective study of such infections (eg, by examining sera for the presence of anti-viral antibodies against viruses known to be capable of initiating orchitis) would seem worthwhile, to identify further potentially important initiators of immunologically-mediated sterility.

Finally, in the present study, the simultaneous occurrence of ASA and AMA tend to implicate infectious hepatitis, whether overt or subclinical anicteric, as well as antecedent biliary cirrhosis, as possible causes of male sterility in some cases. However, no direct proof of infectious hepatitis in the etiology of immunologically-mediated male sterility is established. These are not the only, nor the most prominent causes, and it is not

intended to identify them as such. These diseases are merely presented here as possible initiators of immunologic testicular dystrophy, with consequently resultant sterility. Their importance in the etiology of male sterility has yet to be determined.

Summary

Immunofluorescent studies of anti spermatozoa antibody, anti mitochondrial antibody and anti nuclear antibody, in addition to other autoantibody tests, in 21 infertile couples are presented as evidence that hepatitis and other liver diseases may be precursors of immunologically-mediated sterility.

Acknowledgements

The authors wish to express their gratitude to Mrs. Trisnowati Gordon, Ms. Kyoko Nakata and Ms. Priscilla J. La Forte for their help in typing the manuscript. Finally they wish to thank Mrs. Chiyoko O. Miyabara, Dr. Benjamin L. Gordon and Mr. Michael N. Dennis for their editorial assistance with the manuscript and for other advice and encouragement.

REFERENCES

1. Rumke P, Helling G: Autoantibodies against spermatozoa in sterile men. *Am J Clin Path 32*:357, 1959.
2. Nakabayashi N T, Tyler E T, Tyler A: Immunologic aspects of human infertility. *Fertil Steril 12*:544, 1961.
3. Hjort T, Hansen K B: Immunofluorescent studies on human spermatozoa. 1. The detection of different spermatozoal antibodies and their occurrence in normal and infertile women. *Clin Exp Immunol 8*:9, 1971.
4. Feltkamp T E W, Kruyff K: Autospermagglutinins. *Ann N Y Acad Sci 124*:702, 1965.
5. Rumke P: Serum-agglutinating autoantibodies in relation to male infertility. *Proc Roy Soc Med 61*:275, 1968.
6. Baum J, Boughton B, Morgan J L et al: Autosensitization by sperm in guinea pigs. *Immunology 4*:95, 1961.
7. Beck J S, Edwards R G, Young M R: Immune fluorescence technique and the isoantigenicity of mammalian spermatozoa. *J Reprod Fertil 4*:103, 1962.
8. Hepler O E: Manual of Clinical Laboratory Methods. p. 160 Fourth Edition, 1965, (Charles C. Thomas, Springfield, Illinois.)
9. London W T, Sutnick A T, Blumber B S: Australia Antigen and Acute Viral Hepatitis. *Ann Intern Med 70*:55, 1969.
10. Wright R: Australia antigen and smooth muscle antibody in acute and chronic hepatitis. *Lancet* i:521, 1970.
11. Doniach D, Roitt I M, Walker J G, et al: Tissue antibodies in primary biliary cirrhosis, active chronic (lupoid) hepatitis, cryptogenic cirrhosis and other liver disease and their clinical implication. *Clin Exp Immunol 1*:237, 1966.
12. Berg P A, Doniach D, Roitt I M: Mitochondrial antibodies in primary biliary cirrhosis. *J Exp Med 126*:277, 1967.
13. Robertson J S, Sheard A V: Altered sex ratio after an outbreak of hepatitis. *Lancet* i:532, 1973.
14. Roitt I M, Doniach D: Immunofluorescent test for the detection of autoantibodies. WHO *40*:1-11, 1969.
15. Barnett E V, Holboaow E J (ed.): Standardization in Immunofluorescence. p. 75 (Blackwell, Oxford. 1970).
16. Paronitto F, Shaffner F, Popper H: Antibodies to cytoplasmic antigens in primary biliary cirrhosis and chronic active hepatitis. *J Lab Clin Med 69*:979, 1970.
17. Pesendorfer F, Krassnitsky O, Wewalka F G: Viral hepatitis and tests for the Australia (hepatitis associated) antigen and antibody. Bull. WHO *42*:957, 1970.
18. Haensch R: Fluorescenzimmunologische spermien-autoantikorperbefund bei mannlichen fertilitatsstorungen. *Arch Gynak 208*:130, 1969.
19. Whittingham S, Irwin J, MacKay I R, et al: Autoantibodies in healthy subjects. *Sustr Ann Med 18*:130, 169.
20. Conn H F: Current Diagnosis. p. 21 (W. B. Saunders Co., Philadelphia, PA 19105).

New from Lilly/Dista Research

NALFON®

fenoprofen calcium

300-mg.* Pulvules®

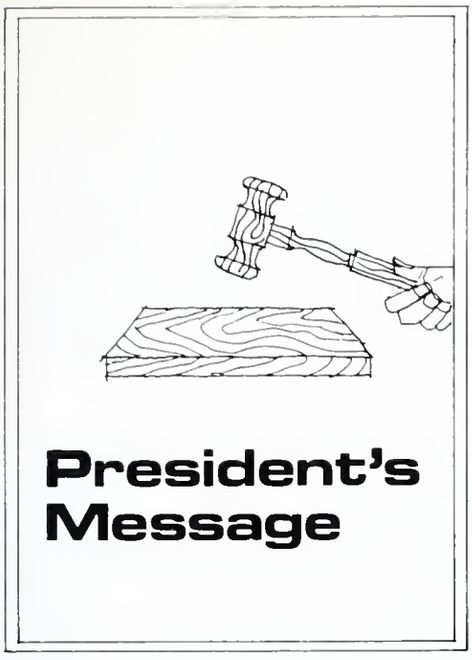
DISTA

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46206

Additional information available to the profession on request.

*Present as 345.9 mg. of the calcium salt of fenoprofen dihydrate equivalent to 300 mg. fenoprofen.

600091



President's Message

William W. L. Dang, M.D.

I think it is appropriate that I try to answer some of the questions raised by Dr. Hubacker in "Letters to the Editor" on page 161.

The most important element of the letter from Dr. Hubacker is the clear and unequivocal evidence that communications are a major problem. This has been made clear on a number of occasions and as yet no one has been able to develop any mechanism to solve the mystery as to how to inform the membership regarding proposals and actions of the House of Delegates. Publication doesn't do it. Meetings are poorly attended and won't do it. Direct mailings to the membership have a very limited response and are very costly. Obviously we cannot send a field representative out to talk to each member.

First of all, the AMA does not have a requirement for what we call "unified" membership, ie, required membership in County Society, State Association, and AMA. This is a requirement of the Hawaii Medical Association and has been for many years. The matter came up for reconsideration in the 1975 House of Delegates and full information was mailed in advance to every county society and to all delegates from every county. The House of Delegates voted to retain the "unified" membership concept. It is true that one of the AMA staff did visit the various counties and discuss the issue. The question, however, was decided in the House of Delegates.

Dr. Hubacker states that he is resigning from the AMA because of the "Dang" plan. His position that this plan provides for a building to be used by the Honolulu physicians is very strange. The building is to be occupied by the HMA offices. The fact that most of the day to day work by committees involves Honolulu physicians should really enlist his support that adequate facilities be obtained for the purpose. The problem of adequate space has plagued us for years and now that we have an opportunity to obtain a building that gives promise of producing income for the future, we would be very short-sighted to not take advantage of it. The committees that will be working in the building are working on behalf of every practicing physician in the state—not just Honolulu. The "Dang" plan as well was publicized to the counties and to the House of Delegates and was voted on by the delegates from every county. Again, this is not a "contribution" but a non-interest bearing loan to enable your association to carry out its purpose for all members.

Just for the record as well, the "Dang" plan was voted on favorably by the House of Delegates as a capital development plan before the 320 Ward Building was considered.

I am sorry to hear that Dr. Hubacker considers his county society as "useless" to the Kona physicians. We realize that the distance across the Big Island is great and meetings are difficult to attend. Nonetheless, the importance of county society organization is very great and will grow. The impact of the local society on the over all peer review process will assume a much larger importance in the near future. The problem of meetings, whether in Hilo, Kona, Waimea, or wherever is not one that can be decided by HMA. This has to be a local decision. The success or failure of peer review depends on the degree of participation of the physician members. Hopefully this can be worked out.

Full and open discussion is welcome. In order for such full and open discussion to be productive, it is essential that all of the discussants do their home work and bring to the discussions a full measure of knowledge upon which to base a decision.



H. Tom Thorson

With assistance by a grant from the Chamber of Commerce a compendium of articles on the development and response of premature infants,

the Sudden Infant Death Syndrome, and related subjects has been collected and housed in the Kapiolani Hospital library.

Never let the right hand . . . DSSH will continue to monitor the findings of the PSRO by reviewing a sample of claims after the PSRO is operative to determine the effectiveness of the PSRO review.

AMA has joined in a suit with the State of North Carolina and the National Association of Regional Councils, contesting the constitutionality of the Health Planning and Development Act (PL 93-641). The suit charges that the act is an intrusion on the rights of the state and local governments by the federal government.

AMA also is protesting regulations proposed for health planning agencies as being contrary to section 1122 of the Social Security Act as contravening the privacy act and having an adverse impact on the availability and quality of health facilities and services.

On the home front—HMA concerned with some provisions of the new malpractice insurance law, proposes to contest constitutionality of the fiscal responsibility section relating to licensure. Early opinion indicates HMA cannot bring a class action for declaratory judgment but will have to work to support an individual who may be denied a license. Legal research is being carried on.

Each County Society has been requested to submit a list of names (Hawaii—4, Honolulu—30, Kauai—4, Maui—4) to the Board of Medical Examiners for consideration as nominees to the conciliation panels that take effect July 1.

HMA is submitting a resolution to AMA supporting a return of the interim (clinical) session to Honolulu after 1980.

Planning to attend AMA Annual Meeting in Dallas, Texas, June 26 to July 1, are Drs. William Dang, Herbert Chinn, George Mills, and Varian Sloan. Dr. Mills is a candidate for Trustee of the AMA.

Meeting in Chicago concerning AMA sponsored insurance company to support mutual insurance companies formed by state associations for malpractice insurance was attended by George Mills.

HMA council on May 28, met and discussed a multitude of things—full report of actions will appear in subsequent issue. One thing of importance, however, was the recommendation that those selected on the panels for the conciliation panel appointments should be trained in the concepts of malpractice. A seminar was recommended in conjunction with the Bar Association to provide all panelists with information as to what constitutes malpractice and how to judge it. Negotiations are under way with the bar association.

Aetna, Medicare Part B was recently asked by the Bureau of Health Insurance to be sure that when doctors accept assignment on the claims that items 9, 10 and 11 on the SSA-1490 are completed. An earlier *Aetna News Bulletin* was sent to physicians in November, 1975 informing them of this Medicare requirement. To avoid any unnecessary phone calls or contacts by Aetna to your office, they are requesting that physicians remind their Medical Assistants to complete the above items. Items 9, 10, and 11 are "total charges," "amount paid" and "any unpaid balance due." Your kokua is much appreciated.

Notice of Position Opening—Assistant Professor, 10% time, for the Department of OB-GYN, John A. Burns School of Medicine, Kapiolani Hospital. Federal Funds, approximate date of hire will be 8-1-76, and duration of appointment will be through 7-31-77. Duties will consist of teaching third and fourth year Medical Students and Residents in clinical and classroom settings. Minimum qualifications: M.D. degree, Board eligibility in OB-GYN, and two years' teaching experience. Please direct inquiries to Ms. Cherlyn Young, 948-7457, and mail curriculum vitae to Dept. of OB-GYN, 1319 Punahou Street, Honolulu, Hawaii 96814.



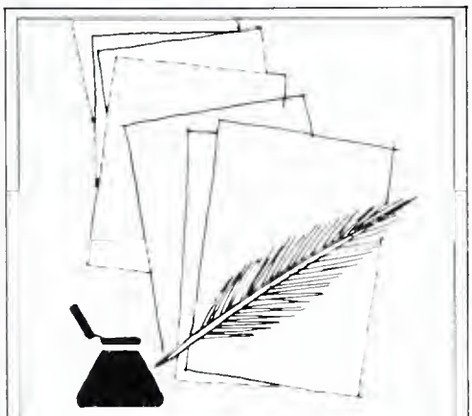
" . . . That's my boy . . . "



New Members



John V. Cuff, M.D.
Hickam Clinic
Hickam Air Force Base
Hawaii, 96553
FAMILY PRACTICE



Editorials

The Physician's Medical Records Are His Alone

By the time this will have gone to press, the Governor may have signed into law H.B. 2700-76, C.D. 1, the Medical Professional Liability Act, or let it become law without his signature; he may also have vetoed it.

Although there are many good reasons why he should veto the bill, the benefits accruing to our society from its becoming the law in our state probably reign paramount.

The Council of the HMA has gone on record in opposition to certain provisions in the bill, and has directed the Ad Hoc Committee to continue its work and to strive to get these unacceptable parts challenged or removed. The HMA position is presented elsewhere in this issue of the JOURNAL, and in the previous issue (HMA News by Tom Thorson).

We direct your attention to what seems like an unimportant matter—until you think about it: Section 15. Chapter 622, HRS, is amended by adding to Part V a new section that will read:

> "Availability of medical records. If a patient . . .requests copies of his or her medical records, the copies shall, if available, be made available to the patient unless . . . it would be detrimental to the health of the patient to obtain the records. If the health care provider is of the opinion that release of the records to the patient would be detrimental to the health of the patient, the . . . provider must advise the patient that copies of the records will be made available to the patient's attorney upon presentation of proper authorization signed by the patient . . ."

The Federal Privacy Act of 1974 (P.L. 93-579) states that individuals are permitted to gain access to information pertaining to them in Federal Agencies' (and their contractors') records. However, the law stipulates that requests for information submitted by Medicare enrollees must be carefully screened by a physician or other qualified, responsible official. If the physician or official determines that the disclosure of the requested information is likely to have an adverse effect on the individual, the information would only be released to a medical practitioner, attorney, member of the individual's family, or other person who is willing to review the record and inform the individual of its contents at the representative's discretion (from *Medicare News* May 1976).

There are no "standard" records kept by physicians. Even in hospitals, the format is as each medical staff chooses to make it. Medical schools teach students the rudiments of recording H & PE's and of progress notes. The Weed Problem-oriented system is an attempt at standardization; very few physicians follow that outline exactly, and neither do the graduating medical students.

A review of the flood of photo-copied office notes now being passed between physicians, not to speak of the stacks of such garbage subpoenaed by the courts, reveals what a wide disparity exists between what is neat, legible, succinct and pertinent, all the way to illegible, verbose, off-on-an-interesting-tangent-but-irrelevant, and finally to hieroglyphic abbreviations and acronyms that leave even their author with a blank and unremembering mind.

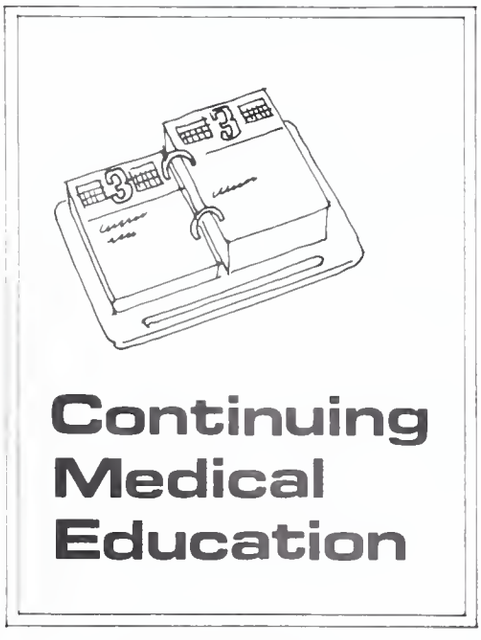
So, what's going to happen? What will be the result of such laws? As is only too often the case, law-makers do NOT analyze the potential ill-effects of non-think. They fail to examine the vectors of force that may be created.

Obviously, the physician will henceforth practice medicine as he plays poker—by keeping his cards close to his vest! Legally defensive medicine, rather than plain good medicine! He will have to record an absolute minimum of only absolutely pertinent information. He should not speculate, in writing, as to differential diagnoses. He should never record possibilities—only steel-hard facts. Or nothing! Perhaps he should tape-record, a la Nixon, everything—and be careful to delete the expletives—of the patient's history in the patient's won words that can be thrown back at him if necessary. The art and the artistry in medicine and the writing thereof is being dealt a body blow!

Ah, but there is an out, or several outs, enough to make a farce of that part of the law. Again, the law-maker's non-think; legislators pass laws that are as full of loopholes as a sieve. ". . . the copies, IF AVAILABLE, . . ." Of course! Just make them unavailable—hide them, destroy them, lose them or spill urine or blood on them! And: " . . . unless . . . it would be detrimental to the health of the patient . . ." Of course! You can always say it is detrimental. And, even when a court or attorney asks for the medical records, your patient can be advised by you to authorize release of only PART of his 20-year volume of complaints and confidences—only the pertinent pages thereof.

What is more basic than any of the above, however, and which is something upon which we as physicians should take a firm stand, is the incontrovertible fact that it is the physician who "owns" his own notes. The patient does not. He has given the information away, to you, for safe-keeping.

J.I.F.R.



CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division
1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m.

Kaiser Hospital
(Contact CME Dept. for further information)

Kauikeolani Children's Hospital
1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program

Kapiolani Maternity Hospital
1. Grand Rounds, Wednesdays, 7:30-8:30 a.m.
2. Resident Conference, Tuesdays (except 1st), 1:00 p.m.
3. Ob-Gyn Department Meeting, 1st Tuesday, 1:00 p.m.
4. UH Seminars, Wednesdays, 3:30 p.m.
5. Perinatal Conference, Thursdays, 3:30 p.m.
6. Tumor Board, 1st & 3rd Fridays, 1:00 p.m.
7. Oncology Conference, 4th Friday, 1:00 p.m.
8. Visiting Professor Program

Kuakini Hospital
1. Hematology Rounds, Monday, 1:00-2:00 p.m.
2. Gastroenterology, Tuesday, 8:00-9:00 a.m.
3. Oncology Conference, Thursday, 8:00-9:00 a.m.
4. Endocrine Conference, 2nd Wednesday each month, 1:00-2:00 p.m.
5. Medical Statistics, 3rd Tuesday each month, 1:00-2:00 p.m.
6. Renal Conference, Wednesdays, 1:00-2:00 p.m.
7. Kidney Biopsy Conference, Tuesdays, 1:00-2:00 p.m.
8. Visiting Professor Program
9. G.I. Rounds, Tuesdays, 8:00 a.m.
10. Infectious Disease Conference, Thursdays, 1:00 p.m.

The Queen's Medical Center
(Contact Medical Staff Office for further information)

St. Francis Hospital
1. Medical Grand Rounds, Tuesdays (4th & 5th), 1:00-2:00 p.m.
2. Surgical Grand Rounds, Fridays (except 4th), 7:30-8:30 a.m.
3. Tumor Conference, Mondays, 7:30-8:30 a.m.
4. Visiting Professor Program
5. Clinical Pathology Topics, Mondays, 10:00-11:00 a.m.
6. Microslide Conferences, Tuesdays, 8:30-9:30 a.m.
7. Bone Marrow Pathology, Tuesdays, 2:00-3:00 p.m.
8. Basic Science Review & Research Conference, Thursdays, 1st & 3rd, 8:00-9:00 a.m.
9. Psychiatric Case Conference, Tuesdays & Fridays, 8:00-9:00 a.m.
10. Psychiatry for the Non-Psychiatrist, Tuesdays, 10:00-11:00 a.m.
11. Psychiatry Teaching Rounds, Thursdays, 9:00-10:00 a.m.
12. Medical Psychiatric Joint Teaching Rounds, Fridays, 11:00-12:00 noon
13. Surgical Mortality & Morbidity Conference, last Friday, 7:30-8:30 a.m.
14. Saturday Teaching Rounds, Saturdays (except 4th), 7:30-8:30 a.m.

Straub Clinic & Hospital
1. Medical Grand Rounds, first Thursday, 7:00 a.m.
2. Surgical Mortality & Morbidity, 4th Thursday, 7:00 a.m.
3. Quarterly Professional Staff Meetings, (Jan., Apr., Aug., Nov.), 4th Monday, 7:30 p.m.

Wahiawa General Hospital
1. Noon Seminars, 2nd Friday & 4th Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:30 p.m. & 2nd Wednesday, 12:30 p.m. of each month in the Mabel Smyth Building. Contact HMA Office as dates are subject to change.

SPECIAL EVENTS

June 20-25 — South Pacific Commission Cancer Seminar at the Pagoda Hotel, sponsored by the American Cancer Society. Contact: John R. Watson, M.D. or Kay VanSant at 531-1662.

August 8-22 — American Cancer Society visiting tutor oncologist: Kenneth B. McCredie, M.D., from M. D. Anderson Hospital in Houston, Texas, will visit each of the major hospitals on Oahu, Maui, Kauai, and Hawaii. For schedule of visits, contact Kay VanSant at 536-5526.

August 9-13 — Emerging Medical, Moral, and Legal Concerns sponsored by St. Francis Hospital and the National Kidney Foundation at the Princess Kaiulani Hotel; 18 hours credit; for more information contact Dr. Arnold Siemsen, 948-7433.

August 14-25 — 19th Annual Postgraduate Referesher Course presented by the University of Southern California School of Medicine and University of Hawaii School of Medicine; Sheraton-Waikiki Hotel; Workshops throughout the morning. Registration $180.00 for Honolulu portion of meeting.

August 23-24 — USC Course on the islands of Kauai and Maui at the Kauai Surf and Royal Lahaina Hotel respectively; 7:30 a.m.-12 noon. Registration fee unknown. For further information contact Phil R. Manning, M.D., University of Southern California, School of Medicine, 2025 Zonal Avenue, Los Angeles, Calif. 90033.

August 28-September 6 — Therapeutics Update sponsored by Postgraduate Education for Physicians in cooperation with the University of California in San Francisco; Maui Surf Hotel; 8:30-11:30 a.m.; Tuition $100; 15 hours Category 1 credit. For further information contact Barry S. Ramer, M.D., Daman-Nelson Travel, 115 Mission Street, San Francisco, California 94105.

Sept. 15-17 — Pediatric Nephrology, presented by the Department of Pediatrics of the University of Hawaii School of Medicine and Kauikeolani Children's Hospital at the Princess Kaiulani Hotel. Tuition is $40.00; registration is required; 16 hours credit. Contact: Sherrel L. Hammar, 226 North Kuakini Street, Honolulu 96817.

October 3-8 — VI Asian Pacific Congress of Cardiology at the Sheraton-Waikiki; contact Dr. Morton Berk for further information at 537-2211.

October 18-22 — American College of Physicians—Workshop in Internal Medicine; Ilikai Hotel; contact Dr. John Kim for further information at 949-5811.

October 25-29 — Hawaii Medical Association Annual Meeting; Ilikai Hotel; contact Bess Chang for further information at 536-7702.

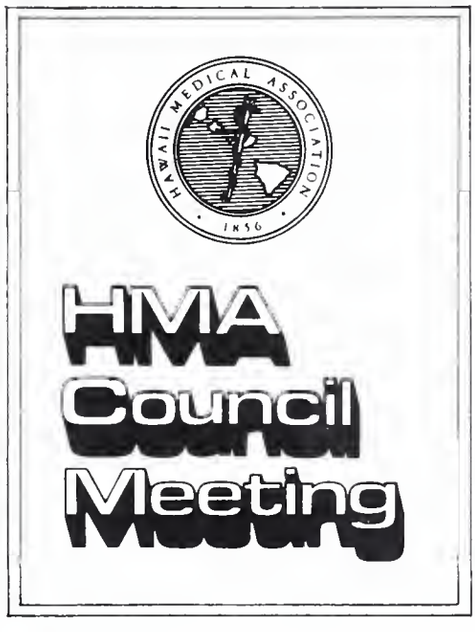
The seminars on "Sexual Counseling: Office Management of Sexual Problems" sponsored by the ACOG and University of Hawaii will be held on the following dates: (20 hrs. credit)

October 18-22 — December 20-24
November 22-26

For further information, write to: American College of Obstetricians & Gynecologists, Department of Continuing Education, I.E. Wacker Drive, Suite 2700, Chicago, IL 60601

OUT OF STATE PROGRAMS

For information on any out-of-state programs or courses, refer to August 11, 1975 Supplement to JAMA or call the HMA Office.



April 23, 1976, 5:30 p.m.
Mabel Smyth Lanai

CALL TO ORDER

The meeting was called to order by President William W.L. Dang. Present were Drs. Winfred Y. Lee, Calvin C.J. Sia, R. Varian Sloan, Grover H. Batten, George H. Mills, Herbert Y.H. Chinn, Albert Chun-Hoon, George Goto, Rowlin Lichter, J.I.F. Reppun, Arnold Siemsen, Sakae Uehara, Peter Kim, Douglas B. Bell II, Clifford Moran, and Kenneth Hughes. Dr. William Moore was seated for Dr. Ann Catts, Dr. Roy Kuboyama was seated for Dr. Carl Lum, and Dr. William Iaconetti was seated for Dr. Rienzi Remitio. Also present were Mrs. Alice Tucker, Mr. V. Thomas Rice, and Dr. Robert Latta.

MINUTES

The minutes of the February 27, 1976, meeting were accepted with minor corrections.

REPORT OF THE SECRETARY

The secretary's report for the month ending March 31, 1976, was circulated. The secretary reported that those members who had not paid their 1976 dues would be dropped from membership on May 1, 1976. A letter of resignation from one member and the response written by the HMA President was circulated.

ACTION:

It was voted to endorse the letter of response written by the HMA president. It was further voted to send a copy of the letter to anyone who resigns from the HMA.

REPORT OF THE TREASURER

The financial statements for January and February 1976 were circulated.

ACTION:

It was voted to accept the financial statements subject to audit.

ACTION:

It was voted to include an itemization of all expenses relating to continuing medical education. It was suggested that the expense to date be included in the next financial statement.

The Dang Plan: A brochure describing the Dang Plan was circulated. The brochure was designed to give basic information on the plan and will be mailed to the entire membership and given to new members as they join. There were no objections to brochure.

It was noted for the record that a poll of the Council on March 23, 1976, indicated a majority agreed that the delinquent date for payments to the Dang Plan would be December 31, 1976.

REPORTS OF THE COMMITTEES AND COMMISSIONS

A. Commission on Public Health: Dr. Robert Latta reported that he had attended a conference of state health administrators at the Communicable Disease Center in Atlanta, Georgia, convened to discuss the swine flu virus. In early February, the swine flu virus was isolated and identified and by March 10 the CDC Practice Committee agreed there were three options to consider: (1) surveillance, (2) production of the vaccine for stockpiling in case of epidemic and (3) immunization of everyone. Option 3 was selected by unanimous vote and the recommendation was made to the Secretary of HEW and approved by the White House Conference on March 24. HMA's Communicable Disease Committee has met with representatives of the Department of Health regarding the swine flu immunization program and will hold further meetings on the subject. The committee recommends that the Council accept the tentative plans of the Department of Health for the implementation of the immunization program and to keep abreast of the development of the program such as the reactions to the vaccine, who will be liable for any complications, etc.

ACTION:

It was voted to approve the recommendation of the Communicable Disease Committee with the condition that final plans for implementation of an immunization program are subject to final approval by the Executive Committee and/or Council.

The Cancer Committee reviewed a request from Dr. Robert Worth relating to endorsement of a study of rehabilitative services to cancer patients and recommends Council approval. The Cancer Commission also reviewed the project and recommends endorsement.

ACTION:

It was voted to endorse the study on rehabilitative services to cancer patients.

B. Internal Affairs: The Convention Committee requested Council approval of the fees for postgraduate courses to be offered at the scientific program of the HMA in October. The committee recommended charges of $10 per session for HMA members and $15 per session for non-HMA members. There was some discussion regarding the use of the funds collected for postgraduate courses and whether or not the speakers depended upon the registration fees for their honorarium.

ACTION:

It was voted to refer the question of sessions charges back to the Convention Committee for clarification, and that the recommendation be forwarded to the Finance Committee and Executive Committee for final approval. It was also recommended that consideration be given to a higher fee for non-members.

Dr. Sloan noted that he will recommend to the House of Delegates that the scientific program and arrangements activities of the annual meeting be separated in future years and that the scientific program activities be placed under the Commission on Medical Education.

The Publications Committee recommends that the Council consider publishing an annual roster beginning in 1977 and that a supplement be printed in 1976.

ACTION:

It was voted to accept the recommendation of the committee.

The AMA Annual Convention will be held in Dallas, June 26-30, 1976, and it was recommended that the HMA delegation submit a resolution asking that the AMA House of Delegates reconsider the decision to hold all interim sessions in Chicago and that Hawaii be selected for an interim session after 1980.

ACTION:

It was voted to submit a resolution as recommended.

C. Commission on Medical Education: The CME Committee is presently reviewing the methodology which might be followed in implementation of a mandatory continuing medical education program which will be required for medical licensure. The committee is also reviewing the credibility of Category 1 programs. Dr. Lee reported that he had contacted the AMA regarding the possibility of holding an AMA Regional CME Meeting in Hawaii and recommended that the Council approve an invitation to the AMA to sponsor a meeting in Honolulu in connection with the 1977 HMA Annual Meeting.

ACTION:

It was voted to approve the recommendation to invite the AMA to hold a regional CME meeting in connection with the HMA's 1977 Annual Meeting.

D. Public Affairs: The winners of the HMA awards for the 19th Hawaiian Science and Engineering Fair were listed for Council information. Two cash awards of $50 and $25 were presented to the top winners; six certificates of achievement were also presented. The HMA and Hawaii Newspaper Agency are sponsoring another public forum on Vision on April 28. Three HMA physicians will serve as panelists. A progress report on the Tel-Med project was presented; there are over 200 tapes in the Tel-Med library and calls average 250 per day. Brochures listing the tapes available have been prepared and will be distributed in banks, physician's offices, hospitals, etc. It was recommended that future publicity include the use of the proper name of the HMA rather than "state medical society." It was also announced that the HMA is participating in the Governor's Bicentennial Conference on Aging which will be held in early June.

E. Health Service and Care: The Community Health Committee has been working on proposed criteria for skilled nursing facilities and has circulated the proposal to all county societies. The committee is also reviewing criteria for intermediate care facilities and would like to have comments from all county societies, especially the neighbor islands.

F. Ad Hoc Committee re Physician Consultants: At the Council meeting of February 27, 1976, an ad hoc committee composed of Douglas Bell II, chairman; and Albert Chun-Hoon, Bernard Fong, and Alan Pavel were appointed to study the request of Argonaut Insurance Company for HMA appointed paid physician consultants to review cases. The ad hoc committee recommends that HMA not allow physicians to be paid as official representatives of the HMA for Argonaut review work but that Argonaut may still bring cases to the committee on a voluntary selective basis and that there is no objection if Argonaut contacts individual physicians for consultant work.

ACTION:

It was voted to approve the committee's recommendation.

G. Legislation: A listing of bills relating to health which were successfully passed by the state legislature was circulated

for Council perusal. The malpractice bill and the Medicaid bill were reviewed by Drs. Chun-Hoon and Kuboyama respectively. Dr. Chun-Hoon noted that the malpractice bill is a good beginning toward solving some of the problems surrounding malpractice. There are certain elements in the bill which will require further action but basically the bill should have a profound effect on malpractice, and especially on the cost of insurance premiums. The four major sections in the bill and effective dates are as follows: (1) The legal doctrine section which includes the prohibition of the *ad damnum* clause and the establishment of criteria for informed consent, and the reporting of information relating to medical tort claims becomes effective January 1, 1977; (2) The Medical Conciliation Panels which will hear all medical tort claims prior to any court proceeding will become effective July 1, 1976; (3) The Patient's Compensation Fund which will cover all malpractice claims over the $100,000 will become effective September 1, 1976. At that time, all physicians who are licensed will be required to be insured for $100,000 or show financial responsibility equal to that amount. (4) Amendments to the Medical Practice Act and amendments to those sections of the law requiring reporting of adverse decisions by peer review committees will become effective upon the approval of the Governor. Dr. Chun-Hoon noted that the Honolulu County Medical Society has called a special membership meeting on May 4 to discuss the malpractice bill and has invited all interested physicians to attend. Dr. Chun-Hoon indicated his willingness to meet with all neighbor island county medical societies as well to review the bill.

Dr. Kuboyama reviewed the Medicaid bill which will allow the DSSH to pay providers of medical, dental, and other professional health care services their usual and customary fees up to the maximum which federal rules permit. The bill also calls for the use of the most current profile in determining the budget.

ACTION:

Drs. Albert Chun-Hoon, George Goto, Roy Kuboyama, and Alan Pavel were commended by the Council for their many contrihutions to the enactment of legislation during the 1976 Legislature. It was also agreed that the HMA should express appreciation to the many legislators who assisted the Association as well as to Attorney Kazuhisa Abe who served as legislative counsel. It was further voted to continue the ad hoc committee on Medical Malpractice and ask that the committee develop their recommendations for possible bylaws changes as a result of new legislation. It was also recommended that the HMA president offer to present a program on the malpractice legislation to neighbor island medical societies if they are interested.

H. Medical Research Task Force: Dr. Chinn reported that the committee is presently reviewing the National Diabetes Act and considering the submission of a grant application for a diabetes project.

I. Ad Hoc Committee on Building Management: Mr. Saranchock presented a report on the planning and preparation for the move to 320 Ward Avenue scheduled for August 2, 1976. He also reported on the current leasing of space. It was recommended that the Committee on Building Management be made a standing committee and that specific guidelines regarding functions and responsibilities of the committee be outlined for Council approval.

ACTION:

It was voted to request the ad hoc committee to present guidelines regarding the functions and responsibilities for a standing committee on building management to the Council for approval. During the interim, it was recommended that the HMA Executive Committee be authorized to give approval for necessary decisions.

J. Bureau of Research and Planning: The Bureau of Research and Planning considered Resolution 20 relating to the office of vice president (House of Delegates action, 1975) and presented their recommendations to the Council.

Your Patient is Our Concern

Artificial Limbs - Orthopedic Supports

Orthopedic and Custom Shoes

Home Care Invalid Equipment

Certified Fitters

C. R. NEWTON CO., LTD.

1575 S. BERETANIA ST.

TELEPHONE 949-8389 or 949-6757

ACTION:

It was voted to receive the report and transmit it to the House of Delegates in October 1976.

K. Cancer Commission/Cancer Center: Dr. Batten presented a progress report on recent commission activities. Dr. Chinn reported that plans for the Cancer Center building have been approved and that space has been allocated for the Hawaii Tumor Registry in the new building. Under present plans, the Hawaii Tumor Registry is scheduled to be relocated to the 320 Ward Avenue building in August 1976. It was suggested that a full report to the Council be prepared outlining all aspects of the proposed relocation and the relationship of the Hawaii Tumor Registry to the HMA and other organizations.

ACTION:

It was voted to request Dr. Batten to prepare a report for the Council as outlined in the discussion above.

L. EMS: The EMS planning contract with the Department of Health for the EMS program on neighbor islands will terminate on June 30, 1976. A grant has been submitted for implementation of the neighbor island program but the status of the grant is unknown. The training program for the EMS project for the City and County of Honolulu will also expire on June 30 and it is expected that contract will be renewed.

M. PL 93-641: The position paper regarding the implementation of PL 93-641 in Hawaii adopted by the Governor's Ad Hoc Committee was reviewed. Public hearings are scheduled for all islands regarding the proposed application for the designation and funding of the State Health Planning and Development Agency (SHPDA). The plan calls for eight subarea health planning councils and all physicians were urged to become actively involved in their respective areas. Dr. Dang noted that Dr. Wayne McKinny and Dr. William Ito presently serve as HMA representatives to the East Oahu Council. Appointments to the other area councils will be forthcoming.

N. PSRO: The Pacific PSRO has received word from the U.S. Department of HEW that the PSRO will become conditional as of July 1, 1976. A phase-in schedule is planned for all acute-care hospitals.

NEW BUSINESS

BBB: Mr. Thorson reported that the Better Business Bureau has contacted the HMA regarding membership. The Council agreed that membership in the BBB should be explored.

ADJOURNMENT

The meeting adjourned at 11:20 p.m.

R. Varian Sloan, M.D.
Secretary

Hawaii Academy of Family Physicians' Newsletter

J.I. Frederick Reppun, M.D.

A NEW MEMBER—Robert F. R. Freeman MD is an Active/Fellow in practice at Lihue, Kauai. Welcome!

A NEW OFFICE BUILDING—Ka Waena Lapa'au, in Hilo, is anxious to have physician tenants.

NEWS OF MEMBERS—Marc Shlachter of Hauula is not only Active but also a Fellow. **Howard Liljestrand** can bask in his son's glory, a vice-versa for once. Bob Liljestrand had a one man exhibit of his beautiful color photos of nature in Hawaii at the Hawaiian Federal S & L, Kapiolani Branch, and beautifully framed. Dad Howard used to be an avid photographer himself. **Ron Hattis** came over from Kauai to participate in HMA's appraisal of the Swine Flu program, making a presentation in depth to the Council. Ron is convinced Washington has gone overboard "whole hog" over the porcine threat for the most piglet of reasons. **Gerald Yorioka** waxed eloquent in Letters-to-the-Editor (*Star-Bulletin 4/28/76*) fending off the proposal by State Rep. Faith Evans RN to regulate rising hospital costs. **Fred Dodge** did get off to The People's Republic of China with the Hawaii-China People's Friendship Ass'n on 5 May. **Mary Glover** went over to the DSSH office in the Liliuokalani Bldg on 27 May to find out about being a representative on the Advisory Committee on EPS/DT (anybody want to guess?) at the request of Irene Fujiwara, Coordinator, who wanted a member from HAFP. We'll be hearing more anon, we trust. **Kevin Kunz,** UHSM '78, is Regional Trustee of AMSA (AM Student A) which held its spring regional meeting 28-31 May in California. **Kathleen Myers,** UHSM '78 wrote to ask HMA for financial support of AMSA.



BLEMISHES?

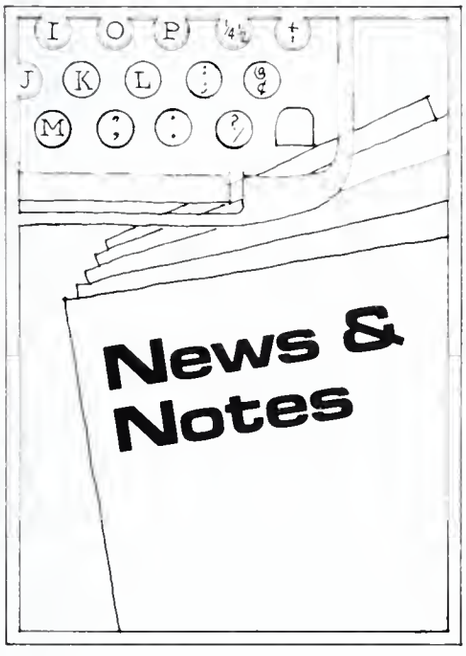
COVERMARK conceals all skin discolorations . . . birthmarks, brown & white patches, broken veins, tattoos, burns, scars, on any part of the body. COVERMARK is also unexcelled as an overall makeup . . . will not rub or flake off. Waterproof and Sunproof.

Lydia O'Leary
OF HAWAII
ALA MOANA CENTER—STREET LEVEL
PHONE 949-3288

MINUTES-IN-BRIEF—of the HAFP Council: Henceforth the monthly meeting will be held on the second instead of the first Thursday of each month, at Children's Hospital. Pres. **Don Farrell** regretfully announced that the Kaiser Family Practice Residency's start has had to be put off to 1 September 1976.

CREDIT HOURS—the big one is coming up: USC-UH 16 - 20 August with a Family Practice section chaired by our **Don Farrell.** 22½ hours of Cat.P is the very maximum obtainable in the Honolulu portion. Hawaii Academy members pay $180.00, all or none, as compared with $250.00 for "foreigners" from the Mainland, etc.

A.A.F.P. PRESIDENT-ELECT—Herb L. Huffington died suddenly on 1 May at his home in Minnesota. A great loss to the Academy. The Hawaii Chapter has expressed and forwarded its condolences. **Robert O. Quello,** Academy Treasurer for 4 years and Board member has been proposed by the Iowa Chapter to fill the vacancy; this will be decided at the annual meeting in Boston in September.



HENRY N. YOKOYAMA, M.D.

Professional Moves

The whisper of activity in the medical community, we described in the last issue, has degenerated to a mere wisp in the last two months, most of the activity being changes in location rather than physicians retiring or starting . . . Honolulu ophthalmologist **Donald Sroat** opened a Kailua branch office at 332 Uluniu Street, while Kailua surgeon, **Robert Rose** (leg still casted) opened a Honolulu office at the Pacific Trade Center for colonoscopy only. Internists **Gordon Liu** and **Bernard Yim** moved to the St. Francis Hospital grounds, 2244D Liliha Street . . . Anesthesiologist **Dan Yoshioka** announced the opening of his office on June 1 but listed only a telephone number and no address . . . In Hilo, **Robert Irvine** and **Robert Harvey** relocated to Ka Waena Lapa-Au, the newly opened Hilo medical complex at 670 Ponahawai.

Elected, Appointed, & Honored

Harold M. Johnson was elected vice president of the American Dermatological Association at its 96th annual meeting in Williamsburg, Va. . . . Hawaii Chapter chairman **Calvin Sia** was recently elected by the membership of District VIII American Academy of Pediatrics as alternate district chairman, and thereby became an executive board member of the American Academy of Pediatrics . . . **Henry Yim,** alternate chairman of the Hawaii Chapter will become chairman while **Fernando Atienza** and **Roy Niimi** will continue as secretary and treasurer . . . At the HMSA annual meeting in May, **Doug Bell, William Spies** and **Stanley Saiki** were elected to the HMSA board.

The American College of Physicians recently named as fellows, internists **Richard Frankel, Roy Kamada, Steven Berman** and **Chew Mung Lum** . . . **Rodman Miller** was selected to represent Pacific Air Forces at the National Security Forum at the U.S. Air Force Air War College, Maxwell AFB., Ala. (Rod was a field artillery officer observer during WWII at the Battle of the Bulge and following medical school, made 16 jumps as a regimental surgeon with the 82nd Airborne Division. He still relaxes by flying gliders from Dillingham Field . . . **Sam Allison** who finished U of Oregon Med School 40 years ago was recently honored with a lifetime alumni membership award for his continued contributions to the activities of the alumni association and to the medical profession . . .

Announcements

Milton Trager, originator of Mentastics, will conduct workshops on Psycho-physical therapy in June at the Esalen Institute and in San Francisco . . .

Miscellany

St. Peter died and arrived in Heaven . . . It was late morning and he had not had breakfast, so he asked another angel where the dining facilities were. The angel pointed to an adjoining cloud where angels were waiting in line . . . St. Peter marched straight to the head of the line for he felt it below his dignity and stature to have to wait, and besides, he was hungry . . . The attendant angel tapped him on the shoulder and explained, "Here in Heaven, we are all treated alike. You must wait in line like anyone else . . ." So St. Peter begrudg-

Rx: Bring your practice to the people.

The Orthodontist moved in as did the Dentist and the Veterinarian. There's still plenty of room for more Dentists, Obstetricians, Pediatricians, Physicians and good ol' G.P.'s.

Check us out then make your diagnosis!
Office space in various sizes just 4 minutes from Pearlridge Mall . . . in the center of **Oahu's fastest growing area.**

NEWTOWN SQUARE
Action Center For Oahu's Fastest Growing Area!

Island Management & Leasing Service
Herbert K. Horita Realty, Inc.
Phone 847-3321 · After 6 call 946-0809

ingly went back to the end of the line. Then he saw an older angel in white jacket and a stethoscope draped on his shoulder walk past and get admitted forthwith . . . St. Peter was annoyed, "I thought we were all treated alike here in Heaven?" The fellow angel explained, "That was God . . . He likes to play doctor." (As told by Tad Iwanuma)

Wine Hints

(For the discriminating penny pincher) By Ed Emura . . .

Sherry: Livingston Cream Sherry by Gallo
Champagne: Gallo
Brandy: Chateau Cliquot
Rose': Almaden
Burgundy: BV
One of Ed's favorites: Chateu Neuf du Pape (Vintage '66, '67, or '70)

Life in These Parts

A grateful **Jack Keenan** whose Physician's Action Group successfully spearheaded efforts to have Medicaid payments raised, wrote sympathetically: "Over the past year or so, our legislators have received their fair share of criticism from the press and the public . . . On the other side of the coin, little has been made of their more positive accomplishments . . ." Jack went on: "On behalf of the Physicians Action Group, I would like to compliment both Houses for their efforts on behalf of the Medicaid patients in the State of Hawaii . . . The adjustments they have seen fit to make in the Medicaid Program Funding have been sorely needed since 1967 and when implanted, will insure a far better standard of medical care for the under-privileged patient." Jack also thanked representatives Stanley and Suwa and senators Toyofuku and Wong, etal. . . .

Reporters were given a lesson in the three "R's" (ie, "wrongs") by **Al Majoska,** City Medical Examiner, at an informal session sponsored by the Honolulu Press Club. Al's three R's were: "Don't misquote me. Don't paraphrase me. Don't edit me." Al was referring to the Moe case in which newspaper accounts made it sound like his autopsy report and QMC pathologist **Hideo Namiki's** report conflicted. Al blasted, "Cooperation is a two way street . . . If the paraphrase comes out wrong, you've taken a side street . . . I don't work for the news media . . . I work for the City . . . You need me more than I need you."

At the Emergency Physicians Seminar at Kaiser, gynecologist **Ronald Berman** reported that of approximately 150 rapes reported in Honolulu in 1973, only 55 alleged rapists were arrested and only seven were convicted, none of whom are in prison now. In 1974, 194 rapes were reported, an increase of 25% and if our situation is similar to that of other cities, more than 800 rapes were probably committed, because 75% go unreported. Ron reported that plans are underway at Kapiolani Hospital to open a rape crisis center with a $200,000 appropriation from the 1975 Legislature.

Tom Thorson's Corner

The Senator was running a close race so he decided to garner the Indian vote . . . He visited the Navajo reservation and spoke to a gathered group . . . "I promise you new schools!" The Navajo's chorused, "Hoya! Hoya!" "I promise you new hospitals!" Again, "Hoya! Hoya!" And so the Senator went on promising everything from new houses to lower taxes, etc., etc. . . . Each time the Navajo's cheered, "Hoya! Hoya!" The Senator was very pleased with himself and with the enthusiastic response and thanked his constituents effusively . . . Next day, he was still in a happy mood and decided to inspect the reservation with his Navajo guide . . . He saw some fine bulls prancing in the pasture and decided to get a closer look at these fine animals . . . The guide warned, "Watch your step, Senator . . . Make sure you don't step on the Hoya . . ."

Visiting Physicians

In March, visiting professor Saul B. Gusberg, OB Gyn Professor and Chairman at Mt. Sinai School of Medicine, reported, "Our studies indicated that women with the highest risk of uterine cancer were overweight, had fertility and bleeding problems because of failure to ovulate. When estrogens became popular as a treatment for menopausal symptoms, the scientists began to see an increased incidence in uterine cancer. The majority of women are given estrogen as replacement, and on a long-term basis, with the idea of preserving youth and preventing coronary disease and osteoporosis. Recent West Coast studies showed that women on estrogen contracted uterine cancer 4½ to 15 times as often as the control group . . . The research shows that if a woman is 20 to 50 pounds overweight, her chances of contracting uterine cancer are 3 times . . . and if 50 or more pounds overweight, her risk is 9 times greater . . . I don't think the average woman needs estrogen replacement therapy because women with menopausal symptoms are in the minority."

Health Dept. Tid Bits . . .

Our usually reliable source says the following questions were raised at a recent Health Dept. meeting on swine influenza . . .

"Is it true that one of the symptoms of this disease is an overwhelming desire to wallow in mud?"

"No, but after you get the shot, you wee wee wee all the way home."

"Is this classified as one of President Ford's 'Pork Barrel' programs?"

Miscellany

Internist **Eugene Matsuyama** explains the "Last Doctor Syndrome" as that situation wherein the last doctor to see the patient has an easier diagnosis because the Sy's and Sx's have fully developed by then . . .

When we commented to **Fred Reppun** how trim he looked of late, Fred shrugged his shoulders and admitted, "I simply practiced what I preach to my patients."

Richard Suehiro of the School of Public Health described the "Dunlap Syndrome" of avoirdupois . . . "The stomach was so fat, it 'dun lap' over . . ."

Our banker friend attended a seminar on human relations and was shocked when the lecturer asked for a 4 letter word ending in "K" and meaning intercourse . . . The answer was "talk" . . .

Hors De Combat

Robert Begam of Phoenix, Arizona, president elect of the 25,000 member Association of Trial Lawyers of America, told a Western Trial Lawyers Association convention at the Maui Surf Hotel that 5 per cent of the nation's doctors are unfit to practice medicine. Robert said, "The trial lawyer has been made the 'scapegoat', the heavy, the bad guy in two areas of social importance, no-fault and medical malpractice insurance . . . But the fact is that in each of these issues, the trial lawyer has been the prober, the diagnostician, the seeker of truth in an attempt to find solutions . . . Studies have shown that 5 per cent of the nation's 320,000 doctors, or about 16,000 licensed physicians, are unfit to practice medicine, and these 16,000 incompetents treat an estimated total of 7.5 million patients each year . . . Despite staggering and mounting evidence of medical mayhem, an average of only 66 medical licenses are revoked nation wide each year . . . The medical profession, instead of policing its ranks to weed out inept practitioners, draws the shades and hides the truth in silent darkness . . ."

The protracted legal battle of former Honolulu neurosurgeon **Maurice Silver** against Queen's and St. Francis hospitals and 3 local neurosurgeons ended another phase when Circuit Judge Harold Shintaku granted summary judgment to the defendants. Judge Shintaku agreed with the defend-

Fast, fast relief for physicians.

We know you'll feel a lot better when your bills get paid promptly. You can get fast service from HMSA if you submit your claims promptly. It will not only keep your accounts current, the cash flow situation in your office will be a lot healthier. HMSA, Hawaii's non-profit medical plan, goes a long way in easing the pains of financial worry.

And we do a better job because of your help.



Hawaii Medical Service Association

ants that Maurice's allegations had already been found to be without merit in earlier decisions by both State and federal courts. In July last year, Circuit Judge John Lanham had declared a mistrial because improper testimony was submitted to the jury and had declared a mistrial after the trial had gone on for a month . . . The decision is expected to be appealed to the State Supreme Court . . .

Al Yuen, HMSA executive vice president, announced that premiums for Plan IV groups will rise by 17 to 18% in the wake of increasing medical costs and in anticipation of more medical care cost hikes—particularly in hospital room rates. Al explained that medical care costs have increased sharply in the past year as a result of increased pay for nurses and the successful negotiations by blue collar workers in hospitals . . . Another factor is the cost of malpractice insurance premiums which is not likely to decrease in spite of the new malpractice legislation.

HMSA president **Donald Nicholson** reported that $76 million was paid out in benefits last year and that HMSA membership had jumped by more than 22,500, bringing the total to more than 474,000 or better than 50% of the state's population . . .

Stemmy Says . . .

Cancer of the stomach is a disease disappearing in the Western World . . . The residuals are in disadvantaged areas . . .

There can be diversity in its frequency within the same country viz lowlands vs highlands and rural vs urban areas . . .

The male to female ratio in Western Europe is 1:5 before ages 50 or 60 and 3:1 thereafter . . .

High risk populations have increased intestinalization (demonstrated by alkaline phosphatase staining) primarily in the Junction Zone, but also in the pylorus . . .

Intestinal type gastric CA is present in high risk populations and in the aged, is seen most frequently in Japan and the Andes, and has a better prognosis than the diffuse type. In Hawaii Japanese and in Norway, there is a decrease in the intestinal type, but the incidence of the diffuse type remains constant . . .

Miscellany

Posted in the doctor's dressing room at QMC: A business card with the following message: "I'd rather do business with one Arab, than with a thousand Jews." On the back of the card, it says, "Finklestein's Funeral Parlor" (Reported by **Walter Young**)

The medical school was faced with an acute housing shortage so the admissions office sent the following questionnaire: "Please state name, address, sex and housing requirements." (Anonymous)

The situation: A pot of gold in a room with four persons . . . viz Santa Claus, Pinocchio, a smart Portuguese and a dumb Portuguese . . . The question: "Who got the gold?" Answer: "The dumb Portuguese . . . Because the others are fictitious characters . . ." (Heard by **Cool Wakai** in the Waialae Country Club shower room)

Visiting Prof Says

John Mills, Professor of Medicine and Microbiology, UCSF lectured on "Use and Misuse of Antibiotics". John remarked, "I'm a lumper rather than a splitter" and proceeded to lump the antibiotics . . .

re, Aminoglycosides: Active and useful in E.Coli, Klebsiella, enterobacter, Serratia, Proteus, and Pseudomonas . . . Indications: Steptomycin for TB, plague; Kanamycin for Coliform, and susceptible bugs; Gentamycin for hospital acquired gram negative bugs, and bugs not susceptible to Kanamycin; Tobramycin for Psuedomonus, and bugs not susceptible to Kanamycin and Gentamycin.

re, Gentamycin dosage: 6mg/kg/d for the first 24 hours and then 3mg/kg/d

re, Toxicity of Aminoglycosides: Renal and ototoxicity are related to dose and individual idiosyncracy . . . The sick patient is monitored with daily serum creatinines, while an ambulatory patient is monitored 2 or 3 times a week . . .

re, Clindamycin: Identical to Lincomycin except attains 4 to 8 times higher blood levels . . . and similar to erythromycin except more toxic (ie, enterocolitis, rash, hepatitis, thrombopenia, leukopenia)

Comparative Sensitivities:

	Staph	Strep	Pneumo	Entero	H. Flu	GNC	Anerobes	Myco
Erythromycin	±	+	+	+	+	+	±	+
Clindamycin	+	+	+	0	0	0	+	(+)

re, Bacteriodes Fragilis: Aminoglycosides: not effective
Clindamycin: Most effective
Other effective drugs: Erythrocin, Lincomycin, Chloromycetin, Rifiampin, high doses of tetracycline.

re, Clindamycin enterocolitis: Lomotil is contraindicated . . .

re, Nail puncture wounds: Beware of pseudomonas . . . Start with Pen G, Pen VK or Cloxicillin. If Staph, then it can be treated easily . . .

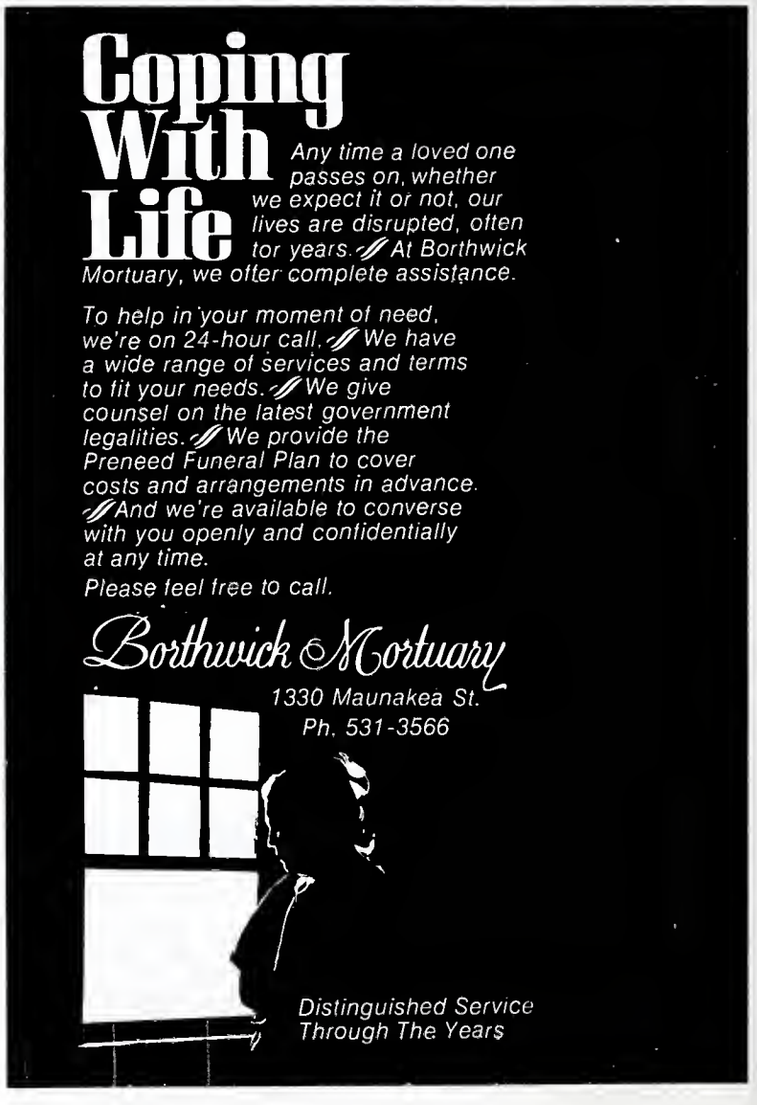
re, Cephalosporins (viz Keflex, Loridine, Ancef, Kefzol, Keflin, Kafocin): "There is no single indication for cephalosporins . . . All cephalosporins were created equal, but some are more equal than others . . . Doctor to patient: "These pills cost $18 per day. Take as many a day as you can afford . . ."

Another Visiting Prof Says . . .

William Haubrick of Scripps Clinic Medical Institute spoke on "Can We Stop the Epidemic of Colon Cancer?"

re, CEA: The CEA test has been completely without value . . . Also in following colon CA cases, I knew well before the tests came back . . .

re, Stool o.b.: We do not rely on stool o.b.



So you got them all through school.



Now what?

It's a great feeling. You got your kids through college and they're on their way. It wasn't easy. Education comes high, these days.

Now, they're gone, and you're thinking of selling the house and finding an attractive condominium.

That's going to leave you with a cash surplus, and a possible tax problem. In fact your whole financial situation will be different now. What does this mean to you?

We specialize in personal financial planning. We can show you how to minimize taxes, how to consolidate and increase your assets, how best to plan for the present.

You helped your kids. Let us help you.

Trust Hawaiian.

Hawaiian Trust Company, Ltd.

Financial Plaza of the Pacific • P.O. Box 3170 • Honolulu, Hi. 96802 • 525-8511
Wailuku Town House • Wailuku, Maui 96793 • 244-7965
120 Pauahi Street • Hilo, Hi. 96720 • 961-3784

re, Procto and Colon CA: The frequency of colon CA is 15% if the proctosigmoidoscopy is negative . . . We have a 0.13% recovery rate from 6,900 procto's . . . Our yield from B.E. is about the same as for proctosigmoidscopy in lesions below 25cm . . .

re, Colon CA and ulcerative colitis: Cancer supervenes in quiescent ulcertive colitis . . .

re, Screening tests: It costs around $12,000 to screen colon-rectal CA . . .

re, Immunotherapy: This may be a possible breakthrough . . .

Conclusion: "There is no single dramatic breakthrough in stopping colon-rectal CA . . . Can we stop the epidemic? . . . Perhaps not now, but we are going to try . . ."

Physicians Speak Up

From Donnelly's Column: "Incidentally, **Dr. Jack Scaff,** who got training underway for the December marathon run, spoke to a public relations society last week and told them this was a 'rest-habituated' and 'nicotine-addicted' society which worries about cancer but then runs headlong to the tomb with cigarettes and lethargy. It was this charismatic speaking ability that not one cigarette was lighted during his talk and nobody left the room for a 'pressing engagement' either . . . Right on . . . Dr. Scaff . . ."

Jack in an appearance on KITV in February on "Word-4-Word" stated that the pressures of modern living and mental stress are not enough to bring about heart attacks. "The active person will not succumb to heart attacks from mental stress alone. President Lyndon Johnson is an example. While president during six very tense years, he never had heart trouble. As soon as he retired to the quiet life, gained weight, started smoking and stopped exercising, he had chest pains on 3 occasions and shortly after died of a heart attack at home." Jack also cited the example of Jews during World War II who had little heart disease despite the constant fear of death in their concentration camp existence.

Ernie Page of Kona complained about the local emergency services: "I know we in Kona are just puppets on a string . . . Just because we are orphans, why should we have to go through Hilo, instead of having a direct telephone to our own Kona fire stations? . . . Our houses burn down or we die due to lack of pulmotors while Hilo is trying to find our residence . . . It is wonderful to live in Kona, but to exist safely, we should live in Kona." /sic/

Willis Butler wrote: "There are too many signs of a whitewash in the air in the death of 'Fiti' Moe." Willis brings up the point that Mace should be used as an alternative to firearms . . . "Are human lives less important than the lives of wild or circus animals, with which tranquilizers work extremely well: Or aren't these methods macho enough?"

Rowlin Lichter was prompted to comment after Chief Keala had recently publicly reprimanded the courts and prosecutors for their laxity and tardiness . . . Rowlin wrote: "It is a sad commentary that in my personal experience /in treating policemen for injuries/ the majority of these on-duty injuries are incurred chasing or apprehending known criminals who have escaped the law either through legal maneuvers, sloppy jailers or court delays . . . Therefore we must add another facet to this deplorable legal game of delay and perhaps, appropriate punishment or restraint . . . Not only are the 'penalties' in this game felt in terms of poor application of the law, decreased security and loss of property; not only are the police forced to suffer further indignity at the hands of the very courts and laws they are trying to defend, but they are also being taxed in terms of physical suffering and actual physical disability and even further, shame upon shame, loss of life! . . ."

Former HMA president and our erudite friend, **Tom Frissell** wrote a lengthy letter to the editor deploring the *Advertiser's* stand on national health insurance (We have herewith tried to extract the meat therefrom). "The *Advertiser* in an editorial comes forth with its yearly advocacy of national health insurance—a euphemism for socialized medicine . . . To equate the Consumer Price Index of goods plus services with services alone (health care) is fallacious . . . One must compare goods with goods and services with services . . . Government intervention in the market could well be the cause of noted increases . . . One of the arguments advanced by the editorial in favor is that the U.S. is the only major industrial country which does not have national health insurance . . . That in itself is good argument against National health insurance! . . . Take a good look at the miserable state of those countries! . . . Many studies show that the majority of the people of this country are in approval of medicine as presently practiced and available . . . At this moment our government consumes 37 percent of the gross national product . . . National health insurance would increase it to 45 percent . . . Also at the moment, 44 percent of all earned income is taken by the government in taxes. What is to be left to the citizen for his own personal disposition? . . . Certainly in general, he could not then afford private care even if desired . . . What will result is the United States will become economically another New York City . . ." (Hear! Hear!)

Fred Reppun, our favorite columnist and Chairman of Neighborhood Board 29 took issue with the *Advertiser* editorial regarding the arrests of peaceful demonstrators from Heeia-kea and from Waiahole-Waikane on the opening day of the Hawaii State Legislature. The editorial had described the arrests as a "minor incident" and that the demonstrators were "interfering with government operations." "We who represent Neighborhood-29, home of many of the so called demonstrators, feel that unless the evidence to the contrary is overwhelming, these arrests should be wiped off the books . . . We also feel that the City Prosecutor did the right thing in refusing to prosecute those arrested, since it appears beyond a reasonable doubt that the arrests were made contrary to the rights of our people to assemble, demonstrate peaceably and petition their government directly . . ."

Our "Angels"

	Page
Bio-Science Laboratories	
Pathology Associates	160
Borthwick Mortuary	182
Hawaii Bancorporation, Inc.	
Bancorp Leasing	188
Hawaii Medical Service Association	181
Hawaiian Trust Company, Ltd.	183
Herbert K. Horita Realty, Inc.	
Newtown Square	179
Kaiser/Aetna	186
Eli Lilly and Company	
Darvocet/Darvon	164
Nalfon	170
C. R. Newton Co., Ltd.	177
Lydia O'Leary	
Covermark	178
Pharmaceutical Manufacturers Association	162, 163
PVO International, Inc.	
Saffola	187
Roche Laboratories	
Valium	158, 159

Index To Volume 33

SUBJECT AND TITLE INDEX

A

Adrenergic Neurotransmitter Storage and Release 371

B

Book Reviews 30,71,298

C

Comparison of Fee-For-Service and Capitation Medicine in a Low Income Group in Honolulu 91
Congenital Toxoplasmosis in Hawaii 243
Critical Evaluation of the Hematoxlyn-Basic Fuchsin-Picric Acid Stain as an Indication of Early Muscle Ischemia 65

D

Dietary Counseling for Persons with Hyperlipoproteinemia 59
Drowning 129

E

Editorials:
- Aloha United Fund 212
- Breast Cancer Detection—A Demonstration Project 140
- But—Please Designate your Gift Anyway 254
- Caucasian? Who Me? 296
- Continuing Medical Education Accreditation Approved 254
- Documentation of Continuing Medical Education (CME) 382
- Is "Defensive" Medicine Often Just Good Medicine 212
- P.S.R.O. 28
- PSRO 172
- PSRO: Tyranny in the Making 70
- Quality Laboratory Care—The New Look 102
- Queen's Will Rise Again 296
- Treating Addiction with Addiction 420
- Waianae's Health Care Woes 255
- We Blew It 254
- Well Done, Henry 340
- You Deserve It, Fred 340

Emergency Medicine at Diamond Head Crater Festival 331

H

HMA Council 29, 213, 256, 341

I

Incidence of HL-A antigens in Japanese Population of Hawaii 23
Intercourse Cystitis 418

L

Letters to the Editor 366

M

Medline Comes to Hawaii 63
Methadone for Heroin Addiction 409
Myotonia Congenita (Thomsen's Disease) . 15

N

New Members 31, 175, 297, 344
News & Notes 32, 73, 103, 142, 174, 214, 258, 299, 383, 485
Non-Automated Multiphasic Health Examination Using Existing Facilities 336

O

Observations on the Allergenic Environment of Okinawa 19

P

Paragonimiasis in Hawaii 329
President's Letter 28
Proceedings of the House of Delegates—118th Annual Meeting 445
Prophylactic Use of Vitamin K During Pregnancy and the Newborn 134
Psychiatry in Hawaii: A Short History 207

R

Racial Distribution of Strabismus—A Statistical Study 22
Rat Mast Cell Degranulation Test in Allergy: Review on Principles and Clinical Application, A 96
Review of Some Tumors of Interest for Demographic Study in Hawaii 283

S

Salt in Baby Foods 131
Seizures Following Sodium Sulfate Therapy for Hypercalcemia in Multiple Myeloma 210
Simplified Guide to the Rational Use of Psychotropic Drugs 201
Status of Surgical Therapy for Coronary Artery Disease 161
Studies on Cancer Mortality in Hawaiian Filipinos, 1961-70 292
Systematic Approach to Sleep Disorders: Review & Treatment 412

T

The Pre-Entrance College Health Examination—A Study of its Cost and Usefulness at the University of Hawaii Student Health Service 248
"Tract Pain Syndrome" Associated with Chronic Cervical Disc Herniation 376

W

Whiplash: Fact, Fantasy, or Fakery— 168

Y

Your Hawaii Medical Library 173

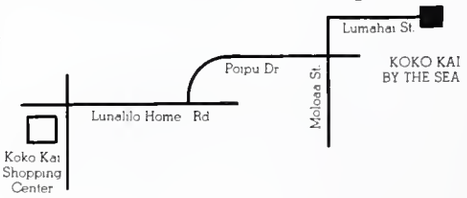
AUTHOR INDEX

Alcantara, A. M. 292
Bennett, B. M. 292
Bolian, George 201
Botticelli, Mas 201
Burns, R. Stanley 331
Char, Donald 248
Chwang, Lei-Chii 131
Euler, U. S. Von 371
Gellar, Jack 210
Glober, Gary 283
Granier, Francis 63
Gulbrandsen, Christian 59
Hankin, Jean 59
Hutchinson-Box, Louise 19
Ing, Malcolm 22
Kim, Chansoo 15
Kinzie, J. David 201, 412
Kobayashi, Satoshi 376
Lerner, Steven 331
Lo, Clifford 96
Markoff, Richard 201, 412
Matsuo, Dorothy 248
McNamara, J. Judson 65, 161
McDanal, Clarence 210
Mehta, B. R. 336
Moser, Robert 129
Nicholson, Maurice 168
Pang, Stephanie 22
Patterson, Wm. 134
Peroff, Ronald 329
Philip, Alistair 243
Quisenberry, Walter 409
Rhoads, George 283
Roy, Johnny 418
Sexton, Patricia 331
Standal, Bluebell 131
Stemmermann, Grant 283
Walker, Walter 63
Wallace, Gordon 243
Worth, Robert 91
Yamada, Shiro 15
Yokoyama, M. Mitsuo 23, 96
Yokoyama, Wayne 23
Zeitlan, Pamela 65

Koko Kai by the sea.



Seven spectacular lots left in Hawaii Kai's last ocean front subdivision. Secluded cul-de-sac. Unbelievable sunsets. Diamond Head. New 55 year lease. This may be your last chance to build your dream home along the ocean. See these lots today. Or call Mr. Chuck Coupe at 373-3175 weekends, 395-2331 weekdays.



A project of KAISER

Saffola® is higher in polyunsaturates than Fleischmann's, Imperial or Mazola.



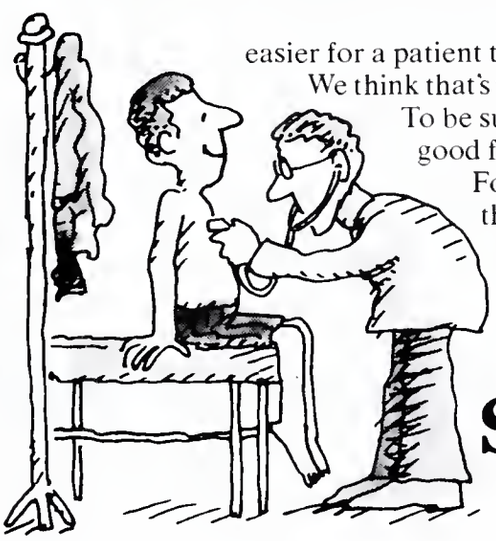
Shouldn't that difference make a difference in what you recommend?

Your patients on modified fat diets can't do better than Saffola. Of the leading margarines, Saffola is highest in polyunsaturates. And no other margarine is lower than Saffola in saturated fats. Because Saffola contains safflower oil—one of nature's most perfect foods. Safflower oil is higher in polyunsaturates than any vegetable oil, including corn oil.

But to your patients, Saffola's good taste is just as important as Saffola's nutrition. The flavor makes it easier for a patient to follow a low cholesterol diet.

We think that's why Saffola is worth recommending.

To be sure your patients are eating what's good for them, and enjoying it.



For comparative information about the nutritional benefits of Saffola, write Consumer Products Division, PVO International Inc., World Trade Center, San Francisco, 94111.

Saffola



WHY LEASE MEDICAL EQUIPMENT?



It may be just what the doctor should order. Take a moment and look into it.

Why lease? Well, it has to do with money. Your money. We're Bancorp Leasing, and we're an affiliate of Bank of Hawaii. Together, we know a lot about how to make your money work for you. When you lease your medical equipment, you've got your hard-earned money available for other more pleasant or profitable investments. And there's no cash outlay either. Leasing is also a tax deductible expense. Leasing through us leaves you and your staff free of the paper work involved in equipment acquisitions. It's our worry.

Give us a call at 537-8810. If you like, we can make an appointment to come out and see you. There's no obligation. Except our obligation to help you get as much out of your capital as possible.

BANCORP LEASING

A subsidiary of Hawaii Bancorporation, Inc.
and an affiliate of Bank of Hawaii

Hawaii Bancorporation Leasing, Inc. / P. O. Box 2900, Honolulu, Hawaii 96846 / Phone 537-8810

JULY, 1976
VOL. 35, NO. 7

HAWAII MEDICAL JOURNAL

CONTENTS

An Investigation of Milk-Drinking Habits of University of Hawaii Students as a Possible Indication of Lactose Intolerance 197
Karen Hastings and Doris M. Hilker

Effective One-Day Colon Preparation for Colonoscopy and Polypectomy 199
Robert A. Rose, M.D.

Continuing Medical Education 210

Editorials 209

Hawaii Academy of Family Physicians' Newsletter 212

HMA Newsletter 208

News and Notes 213

NOTICE: *HAWAII MEDICAL ASSOCIATION OFFICES WILL MOVE TO 320 WARD AVENUE, HONOLULU, HAWAII 96814 ON AUGUST 23, 1976.*

The Library
Acquisitions Division SP
University of California, San Francisco
San Francisco California 94143

LIBRARY
U.C. SAN FRANCISCO
AUG 18 1976


BREATHABILITY...

In bronchospasm*associated with asthma,
chronic bronchitis, and emphysema

MARAX®

TABLETS: ephedrine sulfate, 25 mg; theophylline, 130 mg; Atarax® (hydroxyzine HCl), 10 mg
SYRUP, per 5 ml: ephedrine sulfate, 6.25 mg; theophylline, 32.50 mg; Atarax® (hydroxyzine HCl), 2.5 mg; and ethyl alcohol, 5% v/v

the only bronchodilating/bronchospasmolytic agent with Atarax® (hydroxyzine HCl) instead of barbiturates, which have the potential to depress respiration



* This drug has been evaluated as possibly effective for this indication. See Brief Summary on following page.



Marax®

TABLETS: ephedrine sulfate, 25 mg; theophylline, 130 mg; and Atarax® (hydroxyzine HCl), 10 mg

SYRUP, per 5 ml: ephedrine sulfate, 6.25 mg; theophylline, 32.50 mg; Atarax® (hydroxyzine HCl), 2.5 mg; and ethyl alcohol, 5% v/v

☐ Marax is the only bronchodilating/ bronchospasmolytic agent* with Atarax® (hydroxyzine HCl) instead of barbiturates, which have the potential to depress respiration

☐ Marax contains Atarax to help prevent excessive excitation by modifying the central stimulatory action of ephedrine

* **Indications:** Based on a review of this drug by the National Academy of Sciences—Nationol Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" Effective: For controlling bronchospastic disorders.
Final classification of the less than effective indication requires further investigation.

Contraindications: Because of the ephedrine, Marox is contraindicated in cardiovascular disease, hyperthyroidism, ond hypertension. This drug is contraindicated in individuols who hove shown hypersensitivity to the drug or its components. Hydroxyzine, when administered to the pregnant mouse, rat, and rabbit induced fetal abnormalities in the rat at doses substantially above the human therapeutic ronge. Clinical data in human beings are inadequate to establish safety in early pregnancy. Until such data are available, hydroxyzine is contraindicated in early pregnancy.

Precautions: Because of the ephedrine component this drug should be used with caution in elderly males or those with known prostatic hypertrophy.

The potentiating action of hydroxyzine, although mild, must be taken into consideration when the drug is used in conjunction with central nervous system depressants; and when other central nervous system depressants are administered concomitantly with hydroxyzine their dosage should be reduced.

Patients should be warned—because of the hydroxyzine component—of the possibility of drowsiness occurring and cautioned against driving a car or operating dangerous machinery while taking this drug.

Adverse Reactions: With large doses of ephedrine, excitation, tremulousness, insomnia, nervousness, palpitation, tachycardia, precordial pain, cardiac arrhythmias, vertigo, dryness of the nose and throat, headache, sweating, and warmth may occur. Because ephedrine is a sympathomimetic agent some patients may develop vesical sphincter spasm and resultant urinary hesitation, and occasionally acute urinary retention. This should be borne in mind when administering preparations containing ephedrine to elderly males or those with known prostatic hypertrophy. At the recommended dose for Marax, a side effect occasionally reported is palpitation, and this can be controlled with dosage adjustment, additional amounts of concurrently administered Atarax (hydroxyzine HCl), or discontinuation of the medication. When ephedrine is given three or more times daily patients may develop tolerance after several weeks of therapy.

Theophylline when given on an empty stomach frequently causes gastric irritation accompanied by upper abdominal discomfort, nausea, and vomiting. Administration of the medication after meals will serve to minimize this side effect. Theaphylline may cause diuresis and cardiac stimulation. The amount of Atarax (hydroxyzine HCl) present in Marax has not resulted in disturbing side effects. When used alone specifically as a tranquilizer in the normal dosage range (25 to 50 mg three or four times a day), side effects are infrequent; even ot these higher doses, no serious side effects have been reported and confirmed to date. Those which do occasionally occur when Atarax (hydroxyzine HCl) is used alone are drowsiness, xerostomia and, at extremely high doses, involuntary motor activity, unsteadiness of gait, neuromuscular weakness, all of which may be controlled by reduction of the dosage or discontinuation of the medication. With the relatively low dose of Atarax (hydroxyzine HCl) in Marax, these effects are not likely to occur. In addition, the ataractic action of Atarax (hydroxyzine HCl) may modify the cardiac stimulatory action of ephedrine, and concurrently, increasing the amount of Atarax (hydroxyzine HCl) may control or abolish this undesirable effect of ephedrine.

Marax syrup contains a tartrazine dye (FD&C Yellow No. 5), which has been shown to rarely produce a variety of hypersensitivity reactions, particularly in aspirin-sensitive individuals.

Dosage: The dosage of Marax should be adjusted according to the severity of complaints, and the patient's individual toleration.

Tablets: In general, an adult dose of 1 tablet, 2 to 4 times daily, should be sufficient. Some patients are controlled adequately with 1/2 to 1 tablet at bedtime. The time interval between doses should not be shorter thon four hours. The dosage for children over 5 years of age and for adults who are sensitive to ephedrine, is one-half the usual adult dose. Clinical experience to date has been confined to ages above 5 years.

Syrup: The dose for children over 5 years of age is 1 teaspoon (5 ml), 3 to 4 times daily. Dosage for children 2 to 5 years of age is 1/2 to 1 teaspoon (2.5–5 ml), 3 to 4 times daily. Not recommended for children under 2 years of age.

How Supplied: Marax Tablets are available as light blue, scored tablets in bottles of 100 and 500.

Marax Syrup is available in pints and gallons, and should be dispensed in amber-colored bottles.

ROERIG Pfizer

A division of Pfizer Pharmaceuticals, New York, N.Y. 10017

Hawaii Medical Journal

Published Monthly by the
HAWAII MEDICAL ASSOCIATION
(Incorporated in 1856 under the Monarchy)
510 S. Beretania St., Honolulu, Hawaii 96813

EDITORS

Editor, HARRY L. ARNOLD, JR., M.D.
News Editor, HENRY N. YOKOYAMA, M.D.
Assistant Editor, DORIS R. JASINSKI, M.D., M.P.H.
Contributing Editor, ROBERT H. MOSER, M.D.
Contributing Editor, J.I. FREDERICK REPPUN, M.D.
Book Review Editor, WINFRED Y. LEE, M.D.
Executive Editor, PAUL STEWARD

OFFICERS

President, WILLIAM W.L. DANG, M.D.
President-Elect, CALVIN C.J. SIA, M.D.
Past President, WINFRED Y. LEE, M.D.
Secretary, R. VARIAN SLOAN, M.D.
Treasurer, GROVER H. BATTEN, M.D.

County Presidents

Hawaii, KENNETH HUGHES, M.D.
Honolulu, DOUGLAS B. BELL, II, M.D.
Kauai RIEAZI REMITIO, M.D.
Maui, CLIFFORD MORAN, M.D.
Delegate to AMA, GEORGE H. MILLS, M.D.
Alternate Delegate to AMA,
HERBERT Y.H. CHINN, M.D.

Advertising Representatives
National:
HAWAII MEDICAL ASSOCIATION
510 S. BERETANIA STREET
Honolulu, Hawaii 96813
Phone (808)536-7702
Honolulu:
LILITH JURRY, Phone 946-0053

THE JOURNAL may not be held responsible for opinions expressed in papers, discussions, communications, or advertisements. The advertising policy of the HAWAII MEDICAL JOURNAL is governed by the rules of the Council on Drugs of the American Medical Association. The right is reserved to reject material submitted for editorial or advertising columns. All material for publication must be in the hands of the editor on or before the 10th day of the month preceding publication date. Reprints of original articles will be supplied at actual cost. A reasonable number of illustrations accompanying an article will be accepted for printing. The right is reserved to ask the author to bear cost of these when it is found necessary to do so.

Copyright, 1976 by the Hawaii Medical Association, Honolulu, Hawaii. 2nd class postage paid at Honolulu, Hawaii. Office of Publication: Mabel L. Smyth Memorial Building, 510 S. Beretania St., Honolulu, Hawaii 96813.

TAX SHELTER WITH PLAY!



IN LAS VEGAS

Las Vegas' most beautiful condominium resort on the strip next to the Dunes—across the street from the MGM and the Alladin Hotel.

Compare your pluses:

Tax shelter
Maximum leverage
Entertainment capitol of the world
Many other advantages

Once-in-a-lifetime opportunity to own something of inestimable value under the most advantageous terms and conditions. Prices start from $48,000 cash or may be purchased at 10% down, 360 monthly payments of $332.17 at 8½% annual percentage rate. Condominium units may be placed in a rental program when not in use.

CENTURY PACIFIC, INC.
REALTORS

1027 A Bishop St. Honolulu
Ph. 521-6987

Both often



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

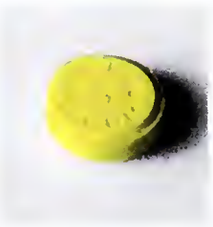
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium®
(diazepam) Ⓥ

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc
Nutley, New Jersey 07110

One contains aspirin.
One doesn't.



Darvocet-N® 100
100 mg. propoxyphene napsylate
and 650 mg. acetaminophen

Darvon® Compound-65
65 mg. propoxyphene hydrochloride,
227 mg. aspirin, 162 mg. phenacetin,
and 32.4 mg. caffeine

Lilly

Additional information available to the profession on request.
Eli Lilly and Company, Inc., Indianapolis, Indiana 46206

500341

Some can drink milk and some can't!

An Investigation of Milk-Drinking Habits of University of Hawaii Students as a Possible Indication of Lactose Intolerance*

KAREN HASTINGS and DORIS M. HILKER, *Honolulu*

• *During the last 15 years numerous reports have shown tht lactose intolerance due to low intestinal lactase activity has a much higher prevalence in some population groups than in others.*

In adults, this prevalence is lowest among those of Northern European extraction and highest among Asians and Africans. It seems to follow a general pattern of being low in areas of the world where dairy products have been readily available and widely used, and high in areas where milk drinking is not common after infancy. Among North American whites the prevalence is low (5-20%), while in African Bantus, Thais, Chinese, Japanese, Filipinos and Eskimos the prevalence may be 90% or more.[1]

In most mammals intestinal lactase is high prior to weaning and declines thereafter. The age at which the lactose intolerance appears in the human is variable, ranging from 2-4 years in Asian and African children to 10-20 years in the U. S. non-white population.[2] Experiments with rats[3] and lactose-intolerant monkeys[4] have shown that lactase activity can be improved by lactose feeding, but attempts to increase lactase activity in humans by feeding lactose have not been successful.[5,6]

Tolerance to milk may be improved by long-term milk consumption. Nandi and Parham[7] compared responses to lactose ingestion along with comparison of milk consumption habits of Asian and white university students concurrently, as children and as adolescents. Their data showed that the two groups differed regarding tolerance to the test dose of lactose, with the Asian group being more tolerant. There was no correlation between milk consumption as adults and lactose intolerance, indicating that lactose intolerant individuals can consume milk in limited amounts.

A study of milk rejection by elementary school children in Baltimore by Bayless *et al*[2] showed that only 13.5% of black and 6.5% of white children consumed less than 50% of the one-half pint of milk provided at the school lunch and were labeled incomplete milk-drinkers. A random sample of these children tested for lactose intolerance showed that of the black incomplete milk-drinkers, 76.6% showed abnormal lactose intolerance tests. Seventeen percent of the white incomplete milk-drinkers showed intolerance, while 35.7% of black milk-drinkers and 20% of the while milk-drinkers had abnormal tests. Factors other than tolerance to lactose also appear to affect milk consumption.

This report concerns a study of the milk-drinking habits of University of Hawaii students of various ethnic groups enrolled in nutrition classes, in relation to symptoms characteristic of lactose intolerance.

Results

A pretested questionnaire was designed to collect information on the quantity of milk and milk products consumed frequently and infrequently, likes and dislikes of milk and milk products and occurrence of symptoms characteristic of lactose intolerance after drinking milk. A total of 127 students completed the questionnaire. Table 1 shows the number of each ethnic group according to the generation the family has resided in the United States. The largest ethnic group repre-

Accepted for publication January 5, 1976.

TABLE 1.—*Generation in the United States*

ETHNIC GROUP	1ST	2ND	3RD	FOREIGN BORN	U.S. BORN
Japanese	1	45	10		56
White (European)		5	24		29
Chinese (U.S. born)		7	2		9
Chinese (foreign)				8	
Other[1]				12	13

[1]Mixed racial groups, Korean, Black, Portuguese, Filipino, Samoan, Hawaiian.

sented was the Japanese, followed by whites and U.S.- and foreign-born Chinese. Twenty-five of the total were mixed racial groups Korean, African, Portuguese, Samoan, Hawaiian or part-Hawaiian classified in the table as "other." Only 14 of the group were males, and all but four were 18-30 years of age. All but one of the Japanese, and all U.S.-born Chinese, were second or third generation, and all had had milk readily available all their lives.

MILK DRINKING HABITS

The consumption of milk and milk products was recorded by the recall method. Ten products (milk, cheese, cheeseburger, ice cream malted milk, imitation milk, yogurt, butter, coffee cream) were listed to determine the frequency of use and whether the subject liked or disliked the product. The categories used for frequency of consumption were (a) 2-3 servings per day, (b) 1 serving per day, (c) 2-3 servings per week, (d) 1 serving per week and (e) monthly or not at all. One serving equalled 1 glass of milk, 1 slice of cheese, 1 cheeseburger, etc., depending upon the food.

Table 2 lists by ethnic group the number and percent of subjects consuming milk frequently (2-3 servings per day) and seldom or never (monthly or less). There was little difference between the percentage of U.S.-born Asian and white students consuming milk frequently. The U.S.-born Chinese had the highest percentage consuming milk frequently, while the foreign-born consumed milk less frequently. Both of these groups, however, were small samples. A survey of consumer demand for milk made in Honolulu between 1959 and 1962[8] showed that per capita milk consumption was approximately 65% of that of the mainland U.S., being higher among whites than the other ethnic groups. However, the milk consumption of whites decreased during this period while the other ethnic groups increased their consumption. The Asians in this study listed nutrition as a more important reason for drinking milk than did the whites. Since the students in our survey were in nutrition classes, the nutritional value of milk would appear to be a major factor in the milk consumption habits of these subject.

TABLE 2.—*Milk consumption by various ethnic groups.*

ETHNIC GROUP	FREQUENTLY[1] NUMBER	%	MODERATELY[2] NUMBER	SELDOM/NEVER[3] NUMBER	%
Japanese (56)[4]	20		26	10	
White (European) (29)	11		14	4	
Chinese (U.S.) (9)	6		2	1	
Chinese (Foreign) (8)	1		5	2	
Other (25)	11		10	4	
Total (127)	49		57	21	

[1] Frequently refers to consumption of 2-3 glasses of milk per day.
[2] Moderately refers to the consumption of from 1 glass of milk per day to 1 glass per week.
[3] Seldom/never refers to consumption of 1 glass of milk per month or less.
[4] Number in parentheses is the number of each ethnic group answering the questionnaire.

ATTITUDES CONCERNING MILK PRODUCTS

Table 2 shows the popularity of the various milk products. All milk products listed were "liked" by a majority of the students, with only imitation milk and yogurt being disliked by 30% or more of the students. Ice cream and cheese were the most popular products, with butter and milk next, being liked by 90% or more of the students.

SYMPTOMS SUGGESTIVE OF LACTOSE INTOLERANCE

The students were asked whether they ever felt slight discomfort, nausea, diarrhea, or vomiting after drinking milk. Of the 127 students answering the questionnaire, only 17 answered "yes" to one or more of the symptoms. The number of subjects experiencing symptoms suggestive of lactose intolerance, according to ethnic group, is shown in Table 3. Foreign-born Chinese had the highest incidence of symptoms, which correlated with the lowest consumption of milk.

TABLE 3.—*Subjects reporting symptoms suggestive of lactose intolerance by ethnic group.*

ETHNIC GROUP	SLIGHT DISCOMFORT	NAUSEA	DIARRHEA	VOMITING
Japanese (56)[1]	6	2	2	
White (European) (29)	1		1	
Chinese (U.S. born) (9)	1		1	1
Chinese (Foreign born) (8)	2		1	
Other (25)	4	2	1	2
Total (127)	13	4	6	3

[1] Number in parentheses represents the total number of each ethnic group answering the questionnaire.

Discussion

The question of whether intestinal lactase activity declines due to lack of substrate when milk is no longer the principal food, or whether the decline is due to genetic control or some other

factor is still a matter of debate. However, from a practical standpoint, our study as well as that of Nandi and Parham[7] indicate that milk and milk products may contribute to the diets of most adults from lactose-intolerant ethnic groups without appreciable discomfort. Both studies showed that Asians increased their milk consumption after coming to the United States, and continued to drink milk in spite of some discomfort. The students from families residing in Hawaii or other states for two generations or more liked and drank milk and ate milk products as frequently as did whites. Also, the U.S.-born oriental students reported fewer symptoms suggestive of lactose intolerance than would be expected, considering the high incidence of lactose intolerance among Asians residing in Asia.

These results suggest that intolerance to milk may not develop in genetically intolerant individuals who continue to drink milk after infancy while those individuals who drink little or no milk after weaning may experience symptoms when attempting to drink milk as children or adults.

Ed. Note. There is some recent evidence that lactase insufficiency may result from early (infantile) infections of the digestive tract and modification of the cellular structure of the gut as a result.

REFERENCES

1. Bayless T: Dissacharide deficiency: JADA 60:478-482, 1972.
2. Bayless TM, Paige DM: Dissacharide intolerance in feeding programs: *Pro West Hem Nutr* Cong: 11 188-196, 1971.
3. Bolin TD, McKern A, David AE: The effect of diet on lactase in the rat. *Gastro* 60:432-437, 1971.
4. Wen CP, Antonowicz I, Tovar E, et al: Lactose feeding in lactose-intolerant monkeys. *Am J Clin Nutr* 26:1224-1228, 1973.
5. Keusch GT, Troncale FJ, Thavaramara B, et al: Lactase deficiency in Thailand: Effect of prolonged lactose feeding. *Am J Clin Nutr* 22:638-641, 1969.
6. Rosensweig ND, Herman RH: Diet and dissacharides. *Am J Clin Nutr* 22:99-101, 1969.
7. Nandi MA, Parham ES: Milk drinking by the lactose intolerant. JADA 61:258-261, 1972.
8. Scott JR, FS: Transition in consumer demand for milk in Honolulu and Kailua. Ag Econ Bill No. 25, HAES, Univ. of Hawaii, 1967.

Effective One-Day Colon Preparation for Colonoscopy and Polypectomy

ROBERT A. ROSE, M.D., *Kailua*

• *The effectiveness of diagnostic colonscopy, and the ease and safety of polypectomy, depend primarily upon the expertise of the colonoscopist and the intraluminal preparation of the colon. In such a potentially hostile environment, the expert colonoscopist very much desires and the novice colonoscopist desperately needs a well-prepared bowel.*

Since January, 1971, we have been using a highly effective 1-day bowel preparation for our barium enema studies.[1-3] When we introduced colonoscopy and polypectomy into our program, the well-established barium enema preparation was modified to make certain that the lower reaches of the colon (i e, recto-sigmoid and sigmoid) were most thoroughly clean, as hostility in this entrance portion of the examination is quite bothersome. Table 1 presents the 24-hour preparation for barium enema studies. Table 2 is the one-day preparation for colonoscopy and/or polypectomy.

The preparation is extremely well received. The only consistent complaint regards the annoyance and irritation of multiple bowel move-

Accepted for publication Nov. 19, 1975

Reprint Requests: Robert A. Rose, M.D., Surgical Endoscopy Unit, Ambulatory Surgery Facility, The Windward Medical Center, 407 Uluniu Street, Kailua, Hawaii 96734

TABLE 1—*A 24 hour preparation for barium enema studies.*

Procedure to be Followed for Morning Barium Enema Examinations

TIME	DIRECTIONS
12 Noon	Lunch——Eat ONLY the following: 1 cup of bouillon soup with crackers 1 white chicken meat sandwich (NO butter, lettuce or other additive) ½ glass of clear apple juice, or clear grape juice 1 serving of plain jello (NO cream, fruit, or other additive) 1 glass of skimmed milk
1 P.M.	Drink one full glass or more of water
3 P.M.	Drink one full glass or more of water
5 P.M.	Supper——Eat ONLY the following: 1 cup of bouillon soup 1 glass of clear apple juice or clear grape juice 1 serving of plain jello (NO cream, fruit, or other additive)
7 P.M.	Drink one full glass of water
8 P.M.	Drink the bottle of MAGNESIUM CITRATE (cold)
9 P.M.	Take three (3) DULCOLAX pills with one full glass or more of water.
	PLEASE REPORT TO THE X-RAY DEPARTMENT ON _____, 19 ___, at _____ A.M.

Nothing to Eat or Drink the Morning of the Examination!

TABLE 2—*A one-day preparation for colonoscopy and/or polypectomy.*

The Following Instructions Should be Carried Out the Day *Prior* to Your Scheduled Colonoscopy Examination:

A.M.	**Breakfast** (Eat ONLY the following) 1 glass of clear apple juice or clear grape juice 1 serving of plain jello (NO cream, no fruit, nor any other additive)
10:00 A.M.	Drink one full glass of water
12:00 Noon	**Lunch** (Eat ONLY the following) 1 cup of bouillon soup with crackers I sandwich made of two slices bread and white chicken meat (NO butter, no lettuce, nor any other additive) ½ glass of clear apple juice or clear grape juice 1 serving of plain jello (NO cream, no fruit, nor any other additive) 1 glass of *skimmed* milk
1:00 P.M.	Drink one full glass or more of water
3:00	Drink one full glass or more of water
5:00 P.M.	**Supper** (Eat ONLY the following) 1 cup of bouillon soup 1 glass of clear apple juice or clear grape juice 1 serving of plain jello (NO cream, no fruit, nor any other additive)
7:00 P.M.	Drink one full glass of water
8:00 P.M.	Drink the bottle of MAGNESIUM CITRATE (cold)
10:00 P.M.	Take three (3) DULCOLAX pills with one full glass or more of water.

MORNING OF EXAMINATION: Two hours before appointment take two warm tap water enemas until returns are clear. Eat the same Breakfast as was prescribed yesterday (see above).

PLEASE REPORT TO THE AMBULATORY SURGERY DEPARTMENT AT _____

ON _____.

(Time) (Day) (Date)

ments that are necessary for proper colon preparation. It is to be noted that we allow patients the option of the 10 ounce bottle of magnesium citrate or 1½ ounces of castor oil. Although both seem effective, patients elect citrate most of the time. In 831 preparations, the following are re-

PRELIMINARY PROGRAM

120th ANNUAL MEETING

October 25 - 29, 1976

Ilikai Hotel - Pacific Ballroom - Honolulu, Hawaii

Theme: "Global Medicine and Diseases of Travel"

Sunday, October 24

2:00 P.M.
REGISTRATION

Monday, October 25

6:30 A.M.
REGISTRATION

7:30 - 9:00 A.M.

POSTGRADUATE COURSE

☐ **A-1 "The New Frontier of Immunology, Part I: Basic Concepts"**

Course Director:
EUGENE M. LANCE, M.D.

Faculty:
DOUGLAS VANN, PH.D.
RONALD W. GILLETTE, PH.D.

PANELS

☐ **"Impact of Recent Immigrants on Infectious Disease Patterns in Hawaii, Part I: Leprosy, Tuberculosis, Measles, and Rubella"**

Moderator:
SCOTT B. HALSTEAD, M.D.

Coordinator:
WASIM A. SIDDIQUI, PH.D.

Panelists:
OLAF K. SKINSNES, M.D., PH.D.
KIRSTEN VENNESLAND, M.D.
NED H. WIEBENGA, M.D.

☐ **"The Increasing Role of Gastrointestinal Endoscopy"**

Moderator:
GARY A. GLOBER, M.D.

Panelists:
TAKAKAZU FUKUMURA, M.D.
W. DAWSON DURDEN, JR., M.D.
ROBERT A. ROSE, M.D.

9:00 - 9:45 A.M.
VISIT THE EXHIBITS

9:45 - 10:45 A.M.
PLENARY SESSION

☐ **"Dietary Fiber and Diseases of Affluence,"**
DENIS P. BURKITT, M.D.

10:45 - 11:30 A.M.
VISIT THE EXHIBITS

11:30 A.M. - 1:00 P.M.

POSTGRADUATE COURSES

☐ **B-1 "Stresses of and Coping with Travel, Part I: Jet Lag and Sleep Disturbances"**

Course Director:
JOHN F. McDERMOTT, JR., M.D.

Faculty:
CHARLES I. BARRON, M.D.
DAVID KINZIE, M.D.
RICHARD MARKOFF, M.D.

☐ **C-1 "Diagnosis and Treatment of Parasitic Diseases, Part I: Discussion on Diagnoses and Treatment of Intestinal Parasites of Man"**

This Continuing Medical Education offering meets the criteria for 16 hours of credit in Category I for the Physician's Recognition Award of the American Medical Association.
Fees are required for postgraduate courses. See registration form.
Panel sessions and plenary sessions included in general registration fee.

Course Director:
WASIM A. SIDDIQUI, PH.D.
Faculty:
KEVIN M. CAHILL, M.D.
WAYNE R. MCKINNY, M.D.

PANEL

☐ **"The Claudicator: Medical, Surgical, and Radiological Considerations"**

Moderator:
THOMAS J. WHELAN, JR., M.D.
Panelists:
ROBERT L. KISTNER, M.D.
DONALD C. NICKON, M.D.
IRWIN J. SCHATZ, M.D.

8:00 P.M.
FIRESIDE CHAT CONFERENCE
(Sponsored by the Hawaii Thoracic Society, Medical Section of the Hawaii Lung Association)
"Pulmonary Medicine"
Lecturer to be announced.

Tuesday, October 26

7:30 - 9:30 A.M.

POSTGRADUATE COURSE

☐ **A-2 "The New Frontier of Immunology, Part II: Immune and Auto-immune Disease"**

Course Director:
EUGENE M. LANCE, M.D.
Faculty:
FRITZ BACH, M.D., PH.D.
SCOTT B. HALSTEAD, M.D.

PANELS

☐ **"Impact of Recent Immigrants on Infectious Disease Patterns in Hawaii, Part II: Toxoplasmosis, Salmonelloses, Cytomegalic Inclusion Disease"**

Moderator:
WASIM A. SIDDIQUI, PH.D.
Panelists:
GORDON WALLACE, D.V.M.
SIDNEY GAINES, PH.D.
NYVEN J. MARCHETTE, PH.D.

☐ **"Disease Patterns in Migrating Populations, Part I: Gastrointestinal and Biliary Tract Diseases"**

Moderator:
GARY A. GLOBER, M.D.
Panelists:
CHARLES S. JUDD, JR., M.D.
MASAO MAESHIRO, M.D.
GUAN BEE ONG, M.D.

9:00 - 9:45 A.M.
VISIT THE EXHIBITS

9:45 - 10:45 A.M.
PLENARY SESSION

☐ **"Food Fads and Diets,"**
SHELDON MARGEN, M.D.

10:45 - 11:30 A.M.
VISIT THE EXHIBITS

11:30 A.M. - 1:00 P.M.

POSTGRADUATE COURSES

☐ **B-2 "Stresses of and Coping with Travel, Part II: Tourism and the Tourist Psychological Problems"**

Course Director:
JOHN F. McDERMOTT, JR., M.D.
Faculty:
LINDA ALEXANDER, PH.D.
BERNICE E. COLEMAN, M.D.
JON STRELTZER, M.D.

☐ **C-2 "Diagnosis and Treatment of Parasitic Disease, Part II: Discussion, Diagnosis, and Treatment of Blood and Tissue Parasites"**

Course Director:
WASIM A. SIDDIQUI, PH.D.
Faculty:
KEVIN M. CAHILL, M.D.
WAYNE R. McKINNY, M.D.

PANEL

☐ **"The Role of Splenectomy in Hematologic Disease"**

Moderator:
C. L. GULBRANDSEN, M.D.
Panelists:
BEN LIN HOM, M.D.
ROBERT W. WILKINSON, M.D.

Wednesday, October 27

7:30 - 9:00 A.M.

POSTGRADUATE COURSE

☐ **A-3 "The New Frontier of Immunology, Part III: Immunotherapy"**

Course Director:
EUGENE M. LANCE, M.D.
Faculty:
NOBORU OISHI, M.D.
LIVINGSTON M. F. WONG, M.D.
BENJAMIN L. GORDON II, M.D.

PANELS

☐ **"Disease Patterns of Migrating Populations, Part II: Cardiovascular Disease"**

Moderator:
DANELO R. CANETE, M.D.
Panelists:
ERNEST K. H. LEE, M.D.
GEORGE G. RHOADS, M.D.
KATSUHIKO YANO, M.D.

☐ **"Drugs of the Decade: New Antibiotics and Prostoglandins"**

Moderator:
VINCENT S. AOKI, M.D.
Panelists:
STEVEN J. BERMAN, M.D.
SANTOSH D. SHARMA, M.D.

9:00 - 9:45 A.M.
VISIT THE EXHIBITS

9:45 - 10:45 A.M.
PLENARY SESSION

☐ **"Diseases of the Tropics"**
KEVIN M. CAHILL, M.D.

11:30 A.M. - 1:00 P.M.

POSTGRADUATE COURSES

☐ **B-3 "Stresses of and Coping with Travel, Part III: Preparing for the Trip"**

Course Director:
JOHN F. McDERMOTT, JR., M.D.
Faculty:
SHELDON MARGEN, M.D.
CHARLES I. BARRON, M.D.
SCOTT B. HALSTEAD, M.D.

☐ **D-1 "Pulmonary Function: The Evaluation"**

This Continuing Medical Education offering meets the criteria for 16 hours of credit in Category I for the Physician's Recognition Award of the American Medical Association.
Fees are required for postgraduate courses. See registration form.
Panel sessions and plenary sessions included in general registration fee.

Course Director:
RUSSELL CARLSON, M.D.
Faculty:
F. W. CHENEY, JR., M.D.
LEE R. JOYNER, M.D.

PANEL

☐ **"Thromboembolism"**

Moderator:
IRWIN J. SCHATZ, M.D.
Panelists:
C. L. GULBRANDSEN, M.D.
ROBERT L. KISTNER, M.D.
CLIFFORD J. STRAEHLEY, M.D.

1:30 P.M.
HOUSE OF DELEGATES MEETING

Thursday, October 28

7:30 - 9:00 A.M.

PANELS

☐ **"Disease Patterns in Migrating Populations, Part III: Carcinoma"**

Moderator:
GRANT N. STEMMERMAN, M.D.
Panelists:
DENIS P. BURKITT, M.D.
MASAO MAESHIRO, M.D.
GUAN BEE ONG, M.D.
CHARLES S. JUDD, JR., M.D.

☐ **"Alimentation and Hyperalimentation: When, Where and How"**

Moderator:
J. JUDSON McNAMARA, M.D.
Panelists:
SHELDON MARGEN, M.D.
JOHN F. BALFOUR, M.D.
WILFRED T. TASHIMA, M.D.
PETER HALFORD, M.D.

☐ **"Drugs of the Decade: Levamisole and Other Promising Drugs"**

Moderator:
VINCENT S. AOKI, M.D.
Panelists:
BENJAMIN L. GORDON II, M.D.
GERALD W. FISCHER, M.D.

9:00 - 9:45 A.M.
VISIT THE EXHIBITS

9:45 - 10:45 A.M.
PLENARY SESSION

☐ **"Influenza: The Last Unconquered Pandemic Disease of Man"**
ALLAN GRANOFF, PH.D.

10:45 - 11:30 A.M.
VISIT THE EXHIBITS

11:30 A.M. - 1:00 P.M.

POSTGRADUATE COURSES

☐ **B-4 "Stresses of and Coping with Travel, Part IV: Man and the Sea**

Course Director:
JOHN F. McDERMOTT, JR., M.D.
Faculty:
FRANK TABRAH, M.D.
BENJAMIN R. FINNEY, PH.D.
EDWARD BECKMAN, PH.D.

☐ **D-2 "Pulmonary Function: The Management of Insufficiency"**

Course Director:
RUSSELL CARLSON, M.D.
Faculty:
F. W. CHENEY, JR., M.D.
LEE R. JOYNER, M.D.

PANEL

☐ **"Arthritis"**

Moderator:
MELVIN H. LEVIN, M.D.
Panelists:
ROGER I. OGATA, M.D.
EUGENE M. LANCE, M.D.

Friday, October 29

9:30 A.M.
HOUSE OF DELEGATES MEETING

Guest Faculty

FRITZ BACH, M.D., PH.D.
Professor of Medical Genetics
University of Wisconsin School of Medicine

CHARLES I. BARRON, M.D.
Medical Director
Lockheed Aircraft Corportion, Burbank, California

DENIS P. BURKITT, M.D.
Medical Research Council, External Staff
London, England

KEVIN M. CAHILL, M.D.
Professor and Chairman of Tropical Medicine
Royal College of Surgeons, Ireland
Director of Tropical Disease Center
Lennox Hill Hospital, New York City

FREDERICK W. CHENEY, Jr., M.D.
Professor of Anesthesiology
University of Washington School of Medicine

ALLAN GRANOFF, PH.D.
Professor and Chairman, Department of Virology & Immunology
St. Jude Children's Research Hospital, Memphis, Tennessee

MASAO MAESHIRO, M.D.
Associate Professor of Surgery
John A. Burns School of Medicine, University of Hawaii (Okinawa)

SHELDON MARGEN, M.D.
Professor of Human Nutrition
University of California, Berkeley

GUAN BEE ONG, M.D.
Professor of Surgery
University of Hong Kong

Faculty

LINDA ALEXANDER, PH.D.
Assistant Professor of Psychiatry
John A. Burns School of Medicine, University of Hawaii

VINCENT S. AOKI, M.D.
Associate Professor of Medicine and Pharmacology
John A. Burns School of Medicine, University of Hawaii

This Continuing Medical Education offering meets the criteria for 16 hours of credit in Category I for the Physician's Recognition Award of the American Medical Association.
Fees are required for postgraduate courses. See registration form.
Panel sessions and plenary sessions included in general registration fee.

JOHN F. BALFOUR, M.D.
Clinical Associate Professor of Surgery
John A. Burns School of Medicine, University of Hawaii

EDWARD BECKMAN, PH.D
Professor of Physiology
John A. Burns School of Medicine, University of Hawaii

STEVEN J. BERMAN, M.D.
Specialist in Infectious Diseases and Associate Professor of Medicine
John A. Burns School of Medicine, University of Hawaii

DANELO R. CANETE, M.D.
Cardiologist and Clinical Professor of Medicine
John A. Burns School of Medicine, University of Hawaii

RUSSELL CARLSON, M.D.
Assistant Professor of Anesthesiology
John A. Burns School of Medicine, University of Hawaii

BERNICE E. COLEMAN, M.D.
Assistant Professor of Psychiatry
John A. Burns School of Medicine, University of Hawaii

W. DAWSON DURDEN, JR., M.D.
Gastroenterologist and Clinical Professor of Medicine
John A. Burns School of Medicine, University of Hawaii

BENJAMIN R. FINNEY, PH.D.
Executive Director of the Polynesian Voyaging Society and Professor of Anthropology
University of Hawaii

GERALD W. FISCHER, M.D., MAJOR, M.C.
Chief, Pediatrics & Infectious Disease Service
Tripler Army Medical Center

TAKAKAZU FUKUMURA, M.D.
General Surgeon, Honolulu

SIDNEY GAINES, PH.D.
Professor, Department of Tropical Medicine & Medical Microbiology
John A. Burns School of Medicine, University of Hawaii

RONALD W. GILLETTE, PH.D.
Director of Basic Science
Cancer Center of Hawaii

GARY A. GLOBER, M.D.
Gastroenterologist and Associate Professor of Medicine
John A. Burns School of Medicine, University of Hawaii

BENJAMIN L. GORDON II, M.D.
Director, Kuakini Hospital
Medical Research Institute and Associate Professor of Tropical Medicine
John A. Burns School of Medicine, University of Hawaii

C. L. GULBRANDSEN, M.D.
Hematologist and Assistant Professor of Medicine
John A. Burns School of Medicine, University of Hawaii

PETER HALFORD, M.D.
General Surgeon, The Honolulu Medical Group

SCOTT B. HALSTEAD, M.D.
Professor and Chairman, Department of Tropical Medicine
John A. Burns School of Medicine, University of Hawaii

BEN LIN HOM, M.D.
Associate Pathologist
Director of Clinical Pathology
The Queen's Medical Center

LEE R. JOYNER, M.D., MAJOR, M.C.
Chief, Pulmonary & Infectious Disease Service
Department of Medicine, Tripler Army Medical Center
Clinical Assistant Professor of Medicine
John A. Burns School of Medicine, University of Hawaii

CHARLES S. JUDD, JR., M.D.
Professor of Surgery and Medical History

120th ANNUAL MEETING - HAWAII MEDICAL ASSOCIATION
October 25-29, 1976, Ilikai Hotel, Honolulu, Hawaii

ADVANCE REGISTRATION

Please print clearly

Name _____

Address _____

City/State/Zip _____

GENERAL REGISTRATION Includes Panel and Plenary sessions but does not include Postgraduate course fees.

HMA Member, Fee Waived ☐
Non-HMA Member, $100 ☐
Interns/Residents/Medical Students, Fee Waived ☐
Other ☐

John A. Burns School of Medicine, University of Hawaii

DAVID KINZIE, M.D.
Associate Professor of Psychiatry
John A. Burns School of Medicine, University of Hawaii

ROBERT L. KISTNER, M.D.
Associate Professor of Surgery
John A. Burns School of Medicine, University of Hawaii

EUGENE M. LANCE, M.D.
Clinical Professor of Surgery
John A. Burns School of Medicine, University of Hawaii
Associate Scientist, Cancer Center of Hawaii

ERNEST K. H. LEE, M.D.
Cardiologist and Clinical Professor of Medicine
John A. Burns School of Medicine, University of Hawaii

MELVIN H. LEVIN, M.D.
Rheumatologist
Associate Professor of Medicine
John A. Burns School of Medicine, University of Hawaii

NYVEN J. MARCHETTE, PH.D.
Professor, Department of Tropical Medicine & Medical Microbiology
John A. Burns School of Medicine, University of Hawaii

RICHARD MARKOFF, M.D.
Associate Professor of Psychiatry
John A. Burns School of Medicine, University of Hawaii

JOHN F. McDERMOTT, JR., M.D.
Professor and Chairman, Department of Psychiatry
John A. Burns School of Medicine, University of Hawaii

WAYNE R. McKINNY, M.D.
Clinical Assistant Professor of Pediatrics
John A. Burns School of Medicine, University of Hawaii
Director of Tropical Medicine Clinic at Children's Hospital

J. JUDSON McNAMARA, M.D.
Professor of Surgery
John A. Burns School of Medicine, University of Hawaii

DONALD C. NICKON, M.D.
Radiologist
The Queen's Medical Center

ROGER I. OGATA, M.D.
Clinical Assistant Professor of Medicine
John A. Burns School of Medicine, University of Hawaii

NOBORU OISHI, M.D.
Associate Professor of Medicine
John A. Burns School of Medicine, University of Hawaii

Director of Clinical Sciences
Cancer Center of Hawaii

GEORGE G. RHOADS, M.D.
Associate Professor
School of Public Health, University of Hawaii

ROBERT A. ROSE, M.D.
Clinical Associate Professor of Surgery
John A. Burns School of Medicine, University of Hawaii

IRWIN J. SCHATZ, M.D.
Cardiologist and Professor and Chairman of Medicine
John A. Burns School of Medicine, University of Hawaii

SANTOSH D. SHARMA, M.D.
Associate Professor of Obstetrics and Gynecology
John A. Burns School of Medicine, University of Hawaii

WASIM A. SIDDIQUI, PH.D.
Professor, Department of Tropical Medicine & Medical Microbiology
Professor of Public Health
John A. Burns School of Medicine, University of Hawaii

OLAF K. SKINSNES, M.D., PH.D.
Professor of Pathology
John A. Burns School of Medicine, University of Hawaii

POSTGRADUATE COURSE REGISTRATION

General registration is required for Postgraduate course participation. Early registration is encouraged as space is limited. Check program for Postgraduate codes and circle your choice. Avoid registering for courses that conflict in time and site. Payment must accompany circled choices.

POSTGRADUATE COURSE CODES

(Circle Choices)

A-1	B-2	C-2
A-2	B-3	D-1
A-3	B-4	D-2
B-1	C-1	

Mail form and check to:

HAWAII MEDICAL ASSOCIATION
510 South Beretania Street
Honolulu, Hawaii 96813

POSTGRADUATE COURSE FEES

HMA Members: $10.00 per 1½ hour class.
Non-HMA Members: $15.00 per 1½ hour class.
Fee waived for interns, residents, medical students

No. of postgraduate courses (HMA Members only) ___ X $10. = $ _____
No. of postgraduate courses (Non-HMA Members only) ___ X $15. = $ _____
Total postgraduate fee $ _____
plus
General registration fee $ _____
TOTAL AMOUNT ENCLOSED $ _____

GRANT N. STEMMERMAN, M.D.
Clinical Professor of Pathology
John A. Burns School of Medicine, University of Hawaii

CLIFFORD J. STRAEHLEY, M.D.
Associate Professor of Surgery
John A. Burns School of Medicine, University of Hawaii
Chief, Department of Surgery, Director of Medical Education, Kaiser Foundation Hospital

JON STRELTZER, M.D.
Assistant Professor of Psychiatry
John A. Burns School of Medicine, University of Hawaii

FRANK TABRAH, M.D.
Professor of Community Health
John A. Burns School of Medicine, University of Hawaii

WILFRED T. TASHIMA, M.D.
Clinical Assistant and Professor of Surgery
John A. Burns School of Medicine, University of Hawaii

DOUGLAS VANN, PH.D.
Associate Professor of Genetics
John A. Burns School of Medicine, University of Hawaii

KIRSTEN VENNESLAND, M.D.
Chief of Tuberculosis Control
Department of Health, State of Hawaii

GORDON WALLACE, D.V.M.
Laboratory of Parasitic Diseases
National Institute of Allergy and Infectious Diseases, Honolulu

THOMAS J. WHELAN, JR., M.D.
Professor and Chairman, Department of Surgery
John A. Burns School of Medicine, University of Hawaii
Program Director, University Integrated Surgical Residency
Program Director, University Integrated Flexible Program

NED H. WIEBENGA, M.D.
Chief of the Epidemiology Branch and State Epidemiologist
Department of Health, State of Hawaii

ROBERT W. WILKINSON, M.D.
Pediatric Hematologist
The Honolulu Medical Group

LIVINGSTON M. F. WONG, M.D.
Associate Professor of Surgery
John A. Burns School of Medicine, University of Hawaii

KATSUHIKO YANO, M.D.
Assistant Director, Honolulu Heart Study

ACTIVITIES

HOUSE OF DELEGATES MEETING

Wednesday, October 27, 1976 - 1:30 p.m.
Friday, October 29, 1976 - 9:30 a.m.

ANNUAL SPORTS AND SOCIAL EVENTS

Annual Banquet - Pacific Ballroom, Ilikai Hotel - October 29
Sportsmen's Night Party - Mid-Pacific Country Club - October 26
Golf Tournament - Mid-Pacific Country Club - October 26

Dates for Deep Sea Fishing, Bow & Arrow Hunting, Skin Diving, Tennis and Ping Pong tournaments will be announced.

ported:

	Numbers	Percent of of Total
Preparation Excellent	671	80.83
Preparation Good	131	15.83
Preparation Fair	71	2.5
Preparation Poor	7	0.83

This particular preparation allows one a clear passage to the cecum, unimpeded by visual impairment due to stool barriers. Modifications of this, or of any preparation regimen, will be necessary in certain instances. If one is committed to a very limited examination, namely that of just the left colon, a very much modified preparation may be utilized.

A rather consistently excellent, or good, colonic intraluminal visual preparation results with the submitted regimen. This short, 24-hour, low residue diet, utilizing a saline type of cathartic (magnesium citrate), followed by a contact type of evacuant such as Dulcolax (bisacodyl NF), and the very important hydration, has been excellent in our hands. In addition to the visual clarity so provided, the absence of any significant stool obviates the necessity for CO-2, nitrogen, or any other inert-substitutive gasses in polypectomies.

REFERENCES

1. Brown Garland R: A New Approach to Colon Preparation for Barium Enema: Preliminary Report. *Univ Michigan Med Bull* 27:225-230, 1961.
2. Barnes Mauvine R: How to Get a Clean Colon—With Less Effort. *Radiology* 91:948-949 passim (Nov.) 1968.
3. Sorrentino AP, Barnes MR, Flack HL: Solving the Barium Enema Problem—the Barium Enema Laxative Kit. *Amer J Hosp Pharm* 26:432-435 (Aug.) 1969.

New from Lilly/Dista Research

NALFON®

fenoprofen calcium

300-mg.* Pulvules®

DISTA

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46206

Additional information available to the profession on request.

*Present as 345.9 mg. of the calcium salt of fenoprofen dihydrate equivalent to 300 mg. fenoprofen.

600091



H. Tom Thorson

Out of the Woodwork—Multiple organizations trying to capitalize on the malpractice situation have popped out. "Doctors Guild" was one, another was the "Condor Trust"—both discredited and in legal trouble. Now another with a new angle—"Malpractice Research, Inc." is soliciting possible claimants and for a fee will evaluate any problem a patient may have and advise as to the viability of a suit. The outfit is in Virginia and is in trouble with the Virginia Attorney General. Anyone hearing of this organization, please contact HMA office.

AMA Annual Meeting in Dallas, Texas is over. Doctor John Budd of Ohio was elected as President-elect. Doctor Richard Palmer of Virginia was installed as President. Hawaii's Dr. George Mills, candidate for the Board of Trustees, was not elected. George did get elected President of the ACES DUECES, an organization of those states having only one or two delegates.

Reference Committee meetings unusually non-controversial. The Committee on Constitution and Bylaws conducted mainly housekeeping chores, revised some of the councils and length of tenure in office and broadened representation on some of them.

Reference Committee A concerned with peer review and its ramifications recommended reimbursement of physicians conducting review and also recommended protection against any liability accruing from their activities. They spent quite a bit of time on PSRO activities and recommended continued monitoring of the PSRO. Supported strongly the idea of usual and customary fee payments under medicaid. A lot of work was done on preserving confidentiality especially in the area of peer review with strong objection being voiced to the use of universal identifiers such as the social security numbers. MODEL LEGISLATION will be drafted relative to confidentiality.

Committee B related largely to legislation with strong resistance being expressed relative to government incursion into the medical care field. The Health Planning law (PL 93-641) came in for a big attack with the major news being on the constitutionality test now going on in North Carolina. Opposition to drug package inserts was strongly expressed particularly to the idea that the inserts could be used as a legal document against a physician. Opposition was expressed to the expansion of the HMO concept. Opposed taxation on medical scholarships as being defeatist.

Committee C dealt largely with medical education, handling such matters as the subject of primary care training before specialty training, education and geographical distribution, essentials of residency training, fellowship training, unions, accreditation of CME programs by state associations, recertification, the use of unlicensed physicians, and the gathering of data on primary care.

Committee D dealt largely with relationships with institutions. Concern was expressed for maintenance of confidentiality of medical audit and utilization review activities. Due process, proper criteria for audit, JCAH standards and guidelines, hospital boards, medical staff relationships, all came in for scrutiny. Medical discipline, staff privileges, physicians responsibility for patient care in teaching institutions, care in nursing homes, mental hospitals, correctional institutions were reviewed.

Committe E directed its attention to concerns for public health matters such as immunizations, environmental problems, television violence, public health education, etc. They directed their attention to family planning and sterilization procedures, hypertension, smoking and health, the ethics involved in the prolongation of life in "hopeless" situations, drug addiction, and the health of athletes.

Committee F directed its approach toward administrative functions of the AMA. They reviewed the auditor's report, examined the dues structure, (NO CHANGE IN DUES), examined AMA contracts, looked over the progress of the long range planning, discussed membership development plans, and made recommendations for time and place of future meetings. They gave encouragement to the filing of suits against DHEW in regard to UR regulations.

THEY RECOMMENDED ACCEPTANCE OF THE HAWAII INVITATION FOR FUTURE MEETINGS TO BE HELD IN HAWAII.

Committee G reviewed internal relationships between AMA and its membership relative to medical discipline, membership polls on various topics, advertising, etc.

Committee H dealt with collateral structures such as AMAERF, Medical Protective Associa-

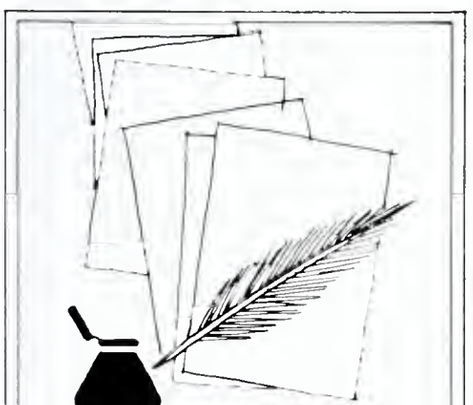
tion, American Medical Assurance Company, Medical Liability Commission, etc.

The above is by no means an exhaustive report on the House of Delegates actions. Approximately 150 resolutions plus 50 reports were considered. While at the meeting conversations were held with legal counsel for the AMA concerning our problem with the new requirement of fiscal responsibility for licensure. Assurance was given that AMA will join with us if suit is filed. Meetings were held with the Council on Scientific Assembly and our invitation for a regional CME conference to be held with our 1977 annual meeting was accepted. The Council estimated that 1000 to 1500 physicians from the mainland could be expected to attend.

In Treatment of Alcoholism the Post-recovery Phase is Crucial—The Hawaii Committee on Alcoholism provides supportive services. For information call 524-1144.

Sierra Club needs physician for Kauai outing, August 2-14. All expenses paid. Call Dr. Robert Nemechek, 261-6656 or 261-4658.

Mrs. J. Gardner (Edith) Bennett, who was Executive Secretary of the Honolulu County Medical Society and the Hawaii Medical Association from 1945 to 1956, and Managing Editor of the HAWAII MEDICAL JOURNAL as well, was married in Fairhope, Alabama, on July 18, to A.W. Robinson, a retired mechanical engineer of that city.



Editorials

You Can Lead A Horse To Water But . . .

Federally funded projects, or at least those that emanate from DHEW, are occasionally worthwhile in terms of the *negative* answers we get. One of these is the Northern Ko'olau Family Health Education Project.

Funded through RMP, the grantee was St. Francis Hospital. The project's initial director was Ms. Vivian Zane, certainly a most capable person. The initial funding was $55,000 for a 10-month period, 9/1/74 to 6/30/75, and, of course, it took a while to get going. Just as the program got into high gear and before any evaluation could be made, the application for a year's extension ran into the usual bureaucratic go/no go, with resultant loss of personnel, a disastrous hiatus in the program and a need to start all over again. However, the new project director, Ms. Marjorie Benning, RN, MPH and trained in midwifery, more than filled Vivian's shoes. The project was granted $50,000 and perhaps even $65,000, which may postpone its expiration until August this year.

With its demise imminent, the project, like the old National March of Dimes which, as Polio was all but eradicated, switched to encompass all diseases of bones, joints and muscles, may now switch to an emphasis on hypertension and asthma. It is changing its acronym to NKCPEP—Northern Ko'olau Community Patient Education Program. It may attract grants from other sources, therefore.

As one of the original program's enthusiastic supporters, I was much interested in feeding into it some 30 patients who had truly severe chronic health problems by dint of being either diabetic, hypertensive, overweight, cardiac, or all four together. I had hoped the project would help those difficult-to-control patients, by means of intensive outreach, to: a) know more about their condition and why they had it, b) understand the severity and the potential adverse consequences of the ailment, c) learn the importance of *regular* care, of no lapses in visits to the doctor nor lapses in taking the prescribed medication, d) learn the significance of following MD prescriptions exactly, and e) get their families and friends to help rather than to hinder accomplishment of stated goals.

Surely, the expenditure of over $100,000 in 22 months (an astronomical figure neither physicians, nor patients, nor third parties can ever hope to afford) in an intensive one-to-one outreach program by well-trained and sincerely-dedicated people of the caliber of the nurse/practitioners in this program, people who have the added incentive of producing "success" in order that the program and its financing would continue, people working with willing and compliant patients, people who maintained close liaison with the patients' physicians and fed back a wealth of useful data that would help the MD in the care of his patients—surely, such a program would be a great success as measured by the benefits to be gained: Understanding, therefore compliance, therefore better control of the affliction—measurable aglycosuria, drop in blood pressure, loss of weight, discontinuance of smoking and dietary indulgences! Better health,

q.e.d.! And, not only that, but this "success" would have to be shown as being above and beyond what could be ascribed to the doctor's solo efforts.

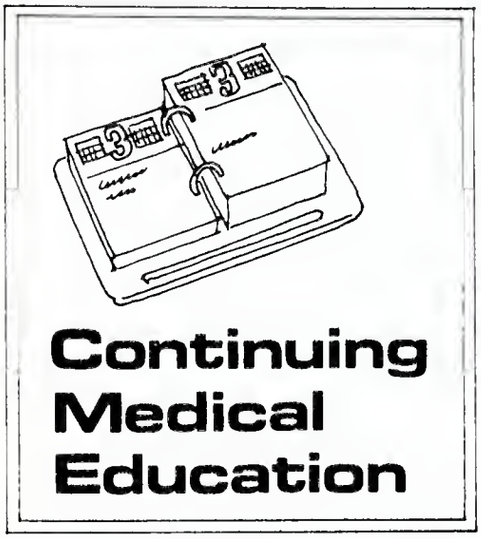
Alas! My hopes have been dashed.

There was initial success, as the patients responded eagerly to something new and different and free. It was fun to receive such personalized attention. However, I have recently analyzed each case carefully; my nurse was less prone than I to give NKFHEP any benefit of the doubt.

I rated only one (1) patient as showing evidence of benefit above and beyond what I myself could claim as credit.

It has been a very expensive way (but maybe worth the dollars spent, for emphasis) of finding out what most of us physicians do know, or should know: That you can lead a horse to water but you can't make him drink.

J.I.F.R.



CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m.

Kaiser Hospital

(Contact CME Dept. for further information)

Kauikeolani Children's Hospital

1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program

Kapiolani Maternity Hospital

1. Grand Rounds, Wednesdays, 7:30-8:30 a.m.
2. Resident Conference, Tuesdays (except 1st), 1:00 p.m.
3. Ob-Gyn Department Meeting, 1st Tuesday, 1:00 p.m.
4. UH Seminars, Wednesdays, 3:30 p.m.
5. Perinatal Conference, Thursdays, 3:30 p.m.
6. Tumor Board, 1st & 3rd Fridays, 1:00 p.m.
7. Oncology Conference, 4th Friday, 1:00 p.m.
8. Visiting Professor Program

Kuakini Hospital

1. Hematology Rounds, Monday, 1:00-2:00 p.m.
2. Gastroenterology, Tuesday, 8:00-9:00 a.m.
3. Oncology Conference, Thursday, 8:00-9:00 a.m.
4. Endocrine Conference, 2nd Wednesday each month, 1:00-2:00 p.m.
5. Medical Statistics, 3rd Tuesday each month, 1:00-2:00 p.m.
6. Renal Conference, Wednesdays, 1:00-2:00 p.m.
7. Kidney Biopsy Conference, Tuesdays, 1:00-2:00 p.m.
8. Visiting Professor Program
9. G.I. Rounds, Tuesdays, 8:00 a.m.
10. Infectious Disease Conference, Thursdays, 1:00 p.m.

The Queen's Medical Center

1. Medical Grand Rounds, Every Friday, 8:00 a.m., Kam Auditorium
2. Surgical Conferences, 1st Tuesday, 4:30 p.m., Kam Auditorium
 Medical-Surgical Conferences, 2nd Tuesday, 4:30 p.m., Kam Auditorium
 Surgical CPC, 3rd Tuesday, 4:30 p.m., Kam Auditorium
 Basic Science Lectures, Every Wednesday, 7:15 a.m., Surgical Conference Room
3. Ob/Gyn Conferences, 2nd and 4th Mondays, 12:30 p.m., Blood Bank Conference Room
4. Pathology Conferences, Every Wednesday, 7:30 a.m., Blood Bank Conference Room
5. Pediatric Grand Rounds, 2nd Wednesdays, 12:30 p.m., Harkness 128
6. Orthopedics Conferences, Every Friday (except the last), 7:30 a.m., Blood Bank Conference Room
7. Tumor Conferences, Last Tuesday, 7:30 a.m., Kam Auditorium
8. Urology Grand Rounds, as designated
9. Psychiatry CME Conference, as designated
10. Neurology/Neurosurgery Conference, as designated

Rx: Bring your practice to the people.

The Orthodontist moved in as did the Dentist and the Veterinarian. There's still plenty of room for more Dentists, Obstetricians, Pediatricians, Physicians and good ol' G.P.'s.

Check us out then make your diagnosis!
Office space in various sizes just 4 minutes from Pearlridge Mall . . . in the center of Oahu's fastest growing area.

NEWTOWN SQUARE
Action Center . . . For Oahu's Fastest Growing Area!

Island Management & Leasing Service

Herbert K. Horita Realty, Inc.
Phone 847-3321 · After 6 call 946-0809

St. Francis Hospital

1. Medical Grand Rounds, Tuesdays (4th & 5th), 1:00-2:00 p.m.
2. Surgical Grand Rounds, Fridays (except 4th), 7:30-8:30 a.m.
3. Tumor Conference, Mondays, 7:30-8:30 a.m.
4. Visiting Professor Program
5. Clinical Pathology Topics, Mondays, 10:00-11:00 a.m.
6. Microslide Conferences, Tuesdays, 8:30-9:30 a.m.
7. Bone Marrow Pathology, Tuesdays, 2:00-3:00 p.m.
8. Basic Science Review & Research Conference, Thursdays, 1st & 3rd, 8:00-9:00 a.m.
9. Psychiatric Case Conference, Tuesdays & Fridays, 8:00-9:00 a.m.
10. Psychiatry for the Non-Psychiatrist, Tuesdays, 10:00-11:00 a.m.
11. Psychiatry Teaching Rounds, Thursdays, 9:00-10:00 a.m.
12. Medical Psychiatric Joint Teaching Rounds, Fridays, 11:00-12:00 noon
13. Surgical Mortality & Morbidity Conference, last Friday, 7:30-8:30 a.m.
14. Saturday Teaching Rounds, Saturdays (except 4th), 7:30-8:30 a.m.

Straub Clinic & Hospital

1. Medical Grand Rounds, first Thursday, 7:00 a.m.
2. Surgical Mortality & Morbidity, 4th Thursday, 7:00 a.m.
3. Quarterly Professional Staff Meetings, (Jan., Apr., Aug., Nov.), 4th Monday, 7:30 p.m.

Wahiawa General Hospital

1. Noon Seminars, 2nd Friday & 4th Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
1. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:30 p.m. & 2nd Wednesday, 12:30 p.m. of each month in the Mabel Smyth Building. Contact HMA Office as dates are subject to change.

SPECIAL EVENTS

KAISER FOUNDATION HOSPITAL
Saturday Morning Educational Conference

August 8-22 American Cancer Society visiting tutor oncologist: Kenneth B. McCredie, M.D., from M. D. Anderson Hospital in Houston, Texas, will visit each of the major hospitals on Oahu, Maui, Kauai, and Hawaii. For schedule of visits, contact Kay VanSant at 536-5526.

August 9-13 Emerging Medical, Moral, and Legal Concerns sponsored by St. Francis Hospital and the National Kidney Foundation at the Princess Kaiulani Hotel; 23 hours credit; for more information contact Dr. Arnold Siemsen, 948-7433.

August 14-25 19th Annual Postgraduate Refresher Course presented by the University of Southern California School of Medicine and University of Hawaii School of Medicine; Sheraton-Waikiki Hotel; Workshops throughout the

DOCTORS: Are your patient files crowding you and your staff out of office space?



TIMES-TWO SPEED FILES *SAVE* 60% OF THE SPACE REQUIRED FOR CONVENTIONAL TYPES OF FILE CABINETS

SAVES VALUABLE FLOOR SPACE

No. Required	Equipment	Lineal Inches	Sq. Feet
4	Four-Drawer file	360	22
1	TIMES-TWO FILE	384	8

PROOF! 63% SAVED! 24 more inches 14 less feet

Please call Carl Spear for complete details and/or demonstration, 521-6724

RECORDS MANAGEMENT SERVICES - HAWAII, PO BOX 211, HONOLULU, HI 96810

HIGUCHI INSURANCE AGENCY, INC.

(808) 531-7091

HONOLULU COUNTY MEDICAL SOCIETY'S
INSURANCE PROGRAM ADMINISTRATOR

TERM LIFE INSURANCE
DISABILITY INCOME INSURANCE
MAJOR HOSPITAL INSURANCE
DEFENDANTS REIMBURSEMENT INSURANCE

morning. Registration $180.00 for Honolulu portion of meeting.

August 23-24 — USC Course on the islands of Kauai and Maui at the Kauai Surf and Royal Lahaina Hotel respectively; 7:30 a.m.-12 noon. Registration fee unknown. For further information contact Phil R. Manning, M.D., University of Southern California, School of Medicine, 2025 Zonal Avenue, Los Angeles, Calif. 90033.

August 28-September 6 — Therapeutics Update sponsored by Postgraduate Education for Physicians in cooperation with the University of California in San Francisco; Maui Surf Hotel; 8:30-11:30 a.m.; Tuition $100; 15 hours Category 1 credit. For further information contact Barry S. Ramer, M.D., Daman-Nelson Travel, 115 Mission Street, San Francisco, California 94105.

Sept. 15-17 — Pediatric Nephrology, presented by the Department of Pediatrics of the University of Hawaii School of Medicine and Kauikeolani Children's Hospital at the Princess Kaiulani Hotel. Tuition is $40.00; registration is required; 16 hours credit. Contact: Sherrel L. Hammar, 226 North Kuakini Street, Honolulu 96817.

October 3-8 — VI Asian Pacific Congress of Cardiology at the Sheraton-Waikiki; contact Dr. Morton Berk for further information at 537-2211.

October 18-22 — American College of Physicians—Workshop in Internal Medicine; Ilikai Hotel; contact Dr. John Kim for further information at 949-5811.

October 25-29 — Hawaii Medical Association Annual Meeting; Ilikai Hotel; contact Bess Chang for further information at 536-7702.

The seminars on "Sexual Counseling: Office Management of Sexual Problems" sponsored by the ACOG and University of Hawaii will be held on the following dates: (20 hrs. credit)

October 18-22 — December 20-24
November 22-26

For further information, write to: American College of Obstetricians & Gynecologists, Department of Continuing Education, I.E. Wacker Drive, Suite 2700, Chicago, IL 60601

OUT OF STATE PROGRAMS

For information on any out-of-state programs or courses, refer to August 11, 1975 Supplement to JAMA or call the HMA Office.

Hawaii Academy of Family Physicians' Newsletter

J.I. Frederick Reppun, M.D.

NEWS OF MEMBERS—George Tyau has been voted in as

BUREAU OF MEDICAL ECONOMICS

"PROFESSIONAL COLLECTION SERVICES FOR HAWAII'S MEDICAL COMMUNITY"

BETTER RESULTS IN COLLECTIONS OF YOUR DELINQUENT ACCOUNTS.

PHONE 536-9691

THE BUREAU OF MEDICAL ECONOMICS
A SUBSIDIARY OF HONOLULU COUNTY MEDICAL SOCIETY.
111 NORTH KING ST., HONOLULU, HAWAII 96817

WILLIAMS MORTUARY

"CHAPEL OF THE CHIMES"

1076 S. Beretania St., Phone 537-2587 **Ample Parking Adjoining Mortuary**

OVER A CENTURY OF SERVICE

"Service measured not by gold but by the Golden Rule"

MEMBER

National Selected Morticians, National Funeral Directors Association,
Order of the Golden Rule, Hawaii Funeral Directors Association

a Life member, from Active. **Mark Wentworth** will be with the Waimea Clinic on Kauai as of 1 August and will be building his own home for his family on the Garden Island. **Lyle Parker,** UHSM '76 dropped out of school in 1975 and is no longer a member. **Paul Esaki MD '76** will be taking his Residency in Oklahoma and will be transferring his membership to that state. **Les Vasconcellos** is no longer in active practice; his membership has been changed to Inactive, therefore. (See below)

NECROLOGY—Members will be saddened to learn that charter member **Joe Lam** died on his 75th birthday, 14 June, at his home. Condolences have been tendered to his family by HAFP.

IMMIGRATION—Hawaii is an attractive place for many people; doctors are no exception and we receive numerous inquiries as to possibilities of setting up practice here. We have asked the Hawaii Medical Ass'n office to be the clearing house for such inquiries, and also to be the central office for openings offered, *locum tenens* desired, and sale of offices and/or practices by local physicians.

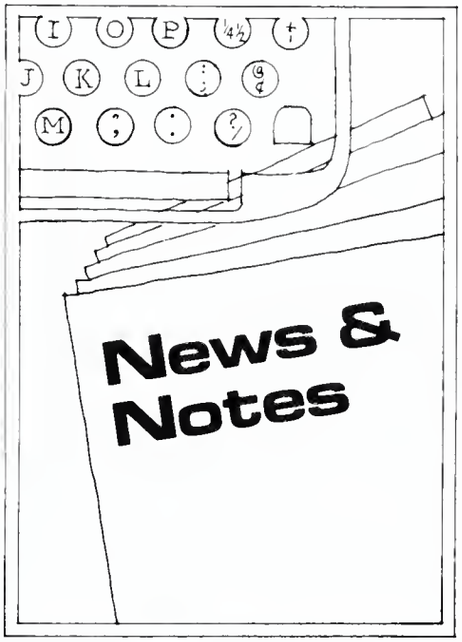
Fully-equipped office available—we make exceptions in the case of our own members! **Les Vasconcellos** owns the office building at 1488 South King St. and is offering his fully-equipped 4-examroom 900+ sq. ft. space for lease, the equipment for sale, terms to be worked out agreeably. It is fully air-conditioned, has a 100 miliamp X-ray and Fluoro. It is on the ground floor; four parking stalls go with it.

DID YOU KNOW?—That only 4% of commonly used drugs (prescription) can be prescribed generically?

DINNER MEETING—The **Drueckers** were hosts at the 26 June Dinner Meeting that featured Sports Medicine with orthopod Bob Smith and Kam School Trainer Glen Beachy. 44 people were present, of which 15 were members. Ex-member Mike Hase and his wife attended. They have been away for 4 years on the Mainland, are seeking a niche here in Hawaii again.

P CREDIT REMINDER—14 to 26 August—19th Annual PG Refresher Course put on by the schools of medicine of USC and UH. 11 members signed up for the Georgia AFP Family Medicine Refresher Correspondence Course 100. Ohio and Connecticut Core Content Review will be starting on 1 October again. NO MEMBER CAN SAY THERE IS A DEARTH!!

VOCIFEROCITY—members **Ron Hattis** from Kauai and **Gerald Yorioka** continue to wax hot and heavy in the newspaper columns on medical and paramedical topics such as swine flu and costs of medical care.



HENRY N. YOKOYAMA, M.D.

Professional Moves

Perhaps this is the lull before the storm, or the drought before the deluge or whatever . . . Anyway, we have seen only

Is the diagnosis ALCOHOLISM?

Time proven alcoholism treatment — formerly available only at Mainland centers — now offered at Post Hospital Recovery Unit, Hilo Care Center.

- A basic, 28-day in-patient program of motivational counseling
- Therapists carefully selected and themselves recovered alcoholics
- Hawaii licensed professional consulting staff in psychiatry, psychology and family medicine
- Privacy, seclusion, total confidentiality in modern facility, beautiful setting

Direct inquiries to:
Marilee Fletcher, Associate Director,
Post Hospital Recovery Unit,
HILO CARE CENTER
944 West Kawailani Street
Hilo, Hawaii 96720 Phone (Hilo) 959-9151

two announcements for June thus far, viz that of OB Gyn man **Richard Williams** joining the Honolulu Medical Group and that of **B.M. Eveleth** and **M. Padwick** announcing that they will open the Kohala Dispensary from Monday through Friday.

On the Health Department front, **Jeremy M.S. Lam,** a pediatrician with a master's in public health, joined the School Health Branch (Jeremy spent several years in the San Francisco area and was variously involved with The Asian Health Services of Oakland, the Learning Disabilities Clinic at Children's Hospital of the East Bay, the Berkley Woman's Health Collective and the Rape Protocal and Exam Scheduling Program at Highland General Hospital, Oakland.) With crusader **Alice Broadhurst** retired and consulting for Hale Makue, a **Sidney B. Clark** with 30 years of public health tours in Panama, Latin America, Mexico, Korea, Paraguay and Iran and more recently a clinic physician at the Alcoholism Treatment Center in San Diego has been appointed Maui health officer.

Life in These Parts

Senator Dan Inouye spoke to 73 graduating interns and resident physicians at Tripler: "When I first went to Washington, I was a staunch believer in the omniscience of federal participation, of having our federal departments actively establish national standards of performance and then orchestrate national policies . . . However, experience over the years has convinced me that perhaps my earlier notions were a bit too simplistic, a bit too idealistic . . . As time passed, my appreciation of providing local autonomy and individual provider participation in all phases of health planning have drastically increased . . ." Dan said it distressed him to see recent charges against the medical profession citing reports that one-third of all hysterectomies are unnecessary, that doctors cheat on Medicare payments, and that drugs are administered in error . . . Dan warned: "Your image has been sorely tarnished and I wish you luck in your efforts to better it."

Lawrence Piette, director of the Cancer Center of Hawaii at the University of Hawaii, reports that their researchers are developing computerized records of the Island's population to help identify groups with a high cancer risk. The center also plans to help physicians treat cancer patients by providing instant information on techniques . . .

Act 219 was signed into law on June 9 by Gov. George Ariyoshi. The new law creates a board of medical examiners and requires specific standards for informing patients of the risks involved in any treatment or surgery. It creates a State medical practice fund in which every doctor in Hawaii will be required to participate and which would pay for all malpractice settlements in excess of $100,000. It requires insurers, not patients and their lawyers, to report details of all malpractice settlements to the State. It eliminates state fund protection for doctors who refuse to settle out of court for less than $100,000, unless they have a strong defense. It requires the State, and not the injured patient, doctor or fund to pay for pretrial costs incurred in the medical claim conciliation panel.

Kaiser emergency room physician and hang-gliding enthusiast, **William Harris,** was at the Makapuu launching pad at 10:45 pm readying his kite for an evening ride when "Mercury" (member of the "Brotherhood of the Source, Aquarians, Eternal Now and the Source" a religious sect which has been in Hawaii since Jan 1975), crashed on take off. Bill climbed down the 100 feet to where Mercury was hanging in an inverted jackknife position from his harness, bleeding and unconscious. Mercury woke up for a short period. "He shouted, 'Get me out of here!' I reassured him we'd try to help him. Ten minutes later he died." It took 2 hours to get Mercury's body back up the cliff and summon the police. But Source members had decided to take the dead Mercury back to their Lanikai home "to allow the soul to leave the body" (by keeping the body untouched for 3½ days).

Elected, Appointed, Honored

On the heart front: **Danelo Canete** was elected president of the Hawaii Heart Association succeeding **James Orbison** who



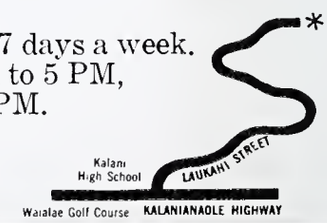
LAST OF ITS KIND IN THIS AREA!

Here "at the top . . ." overlooking the grandeur of the valley and sea below is a lifestyle that's second to none. To top it off, Waialae Iki IV is your last chance to custom build and assure a sweeping view from Diamond Head to Koko Head. Your architect or ours, your home design or ours, or a combination of ideas . . . let's talk about your home on the hill in Waialae Iki IV.

From **$163,400** including heated pool. Leasehold.

Model home open 7 days a week. Weekends, 10 AM to 5 PM, Weekdays, 1 to 5 PM.

New models with heated pools soon to be constructed.



WAIALAE IKI IV

Herbert K. Horita Realty, Inc. Kalihi Phone: 847-4241/Waimalu Phone: 487-1561/Waikiki Phone: 922-3377

served two years as president. **Sam Gresham** was elected President-elect and **Douglas Bell II** Vice President. Reelected to the Board were **Ed Chesne, Judson McNamara, Alfred Morris, Jordon Popper,** and **Mark Sowers.** Newly elected to the board were **Terry Claggett, John Edwards, Edgar Ho** and **James Hastings.** On the cancer front: **Carl Boyer Jr.** was elected president of the new Honolulu unit of the American Cancer society. **Edwin Dierdorff** was elected First Vice President of the Windward Unit of the American Cancer Society. Elected to the board were **F.E. Ceccarelli, Edwin Dierdorff, Harold Lawson, Robert Rose, Glenn Stahl, Carla Crim, Raymond deHay, George Mills** and **Kazushi Tanaka.** The Windward Unit, the Honolulu Unit and Central/Leeward Units will replace the present Oahu Unit. Russell Stodd was elected to the board of the Maui Unit of the American Cancer Society. On the alumni front: **Duke Cho Choy** was honored by the McKinley class of '36 at its reunion banquet in May. Duke was senior class president and was chosen by his class as the greatest humanitarian of the McKinley Class of '36 . . . **Richard Lundborg,** chief of anesthesiology at Hilo Hopsital, received the Distinguished Alumni Award in Medicine at the recent reunion banquet of the Gustavus Adolphus College . . . **John F. McDermott, Jr.,** chairman of the department of psychiatry at John Burns School of Medicine, was honored at the alumni banquet of the New York Medical College where he was named outstanding alumnus for 1976 . . . John is a 1955 graduate . . .

Sportsmen

Golfer **Tosh Kawasugi** usually plays golf with **Tsuyoshi Yamashita, Tom Oshiro** and **Shozo Ogawa** at Mid Pac CC, but recently when Mid Pac had its annual 3-man team tournament, Tosh found himself ousted by his three golfing friends. Tosh swallowed his pride and joined a pair of golfers looking for a 3rd. Then Tosh proceeded to shoot a 16 under, practically by himself, so that his team came in first place and in the money (much to the chagrin of his ex-partners) . . .

DDD Tournament

(Held at Hawaii Kai CC on Apr. 22)

The closely contested tournament ended in a 4 way tie with **William Dang, Ernesto Orinion, Al Parez** and **Kurashima** shooting net 67's. The problem was partially solved when Bill Dang settled for 1st Place C flight and the remaining 3 tossed coins to determine the winner of the overall low net, a TV set. Ernesto won and Al Parez settled for 1st Place B. (What happened to Kurashima? We haven't found out . . .)

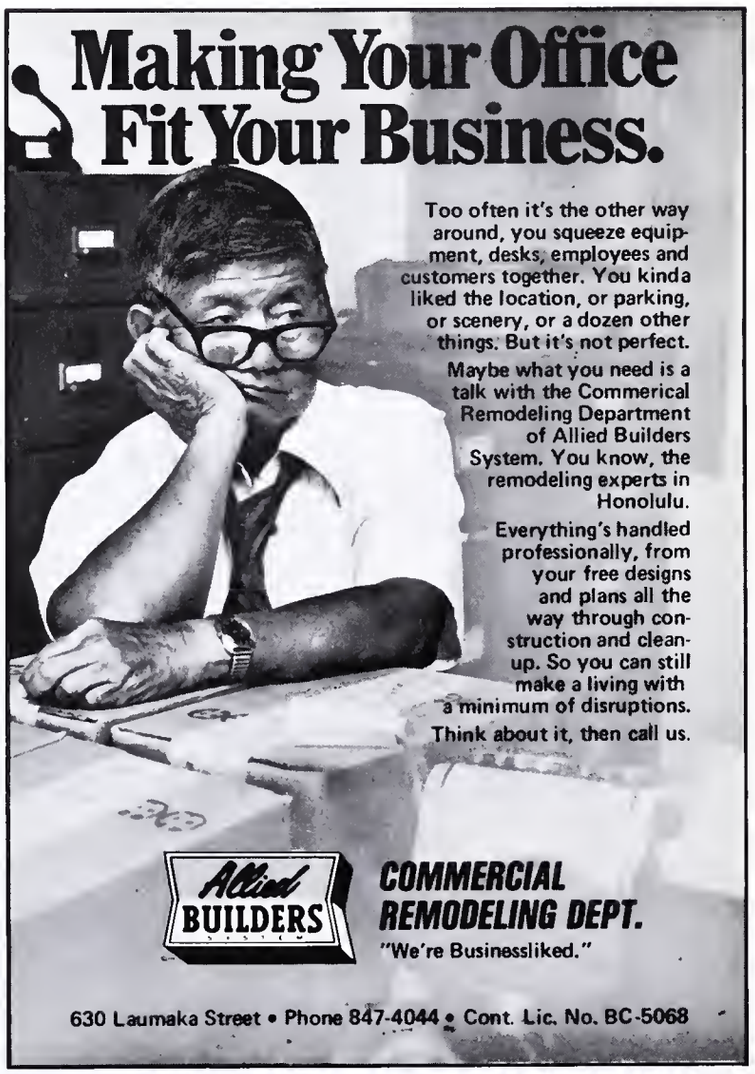
In C Flight, **Bill Dang** with net 67 was 1st, **Art Salcedo** with net 69 was 2nd and **Randal Nishijima** and **Wyman Tong** with net 71's were in 3rd place. At net 72 was **Larry Winter,** at net 73 were **Ross Hagino** and **J. Wong** and at net 74 were **Henry Fong** and **K.S. Tom.** In B Flight, **Al Parez** was first, **Manuel Abundo** and **Roy Iritani** with net 71's were tied for 4th place; **Paul Sunahara** with net 72 was in 6th place and **Alan Luning** with net 73 was in 7th.

A Flight was won by **Mike Okihiro** with his net 68. At the post tournament festivities at Kanraku Tea House, **Don Maruyama** went up to receive Mike's prize (in Mike's absence) and casually asked if his own net 68 counted. A quick check by the tournament committee revealed the oversight and after deft maneuvering, a similar clock radio prize was found and presented to Don. After the party, Don very happily carried both clock radios in their paper cartons to his Porsche. He carefully placed both boxes on his car top to unlock his door. Then he promptly lowered himself into the bucket seat and sped off . . . What about the two A Flight 1st prizes left on the car top? Several blocks later, Don suddenly remembered. He stopped, checked an empty roof top, hastily drove back to the Kanraku parking lot. But alas! no clock radios. Don asks that anyone who may have found two brand new clock radios either in the parking lot or down the street aways, please contact either him or Mike Okihiro . . .

Under the Callaway system, **James Harrison** with net 74 was 1st, **Doug Bell** with 75 was 2nd and **Milton Trager** with net 75½ was 3rd. **Francis Au** with net 78 was 5th . . .

Our "Angels"

	Page
Allied Builders	215
Bureau of Medical Economics	212
Century Pacific, Inc.	193
Hawaii Leasing	218
Herbert K. Horita Reality, Inc.	
Newtown Square	210
Waialae Iki IV	214
Higuchi Insurance Agency, Inc.	212
Hilo Care Center	213
Eli Lilly and Company	
Darvocet/Darvon	196
Nalfon	207
Pharmaceutical Manufacturers Association	216, 217
Records Management Services	211
Roche Laboratories	
Valium	194, 195
Roerig, A Division of Pfizer Pharmaceuticals	
Marax	190, 191, 192
Williams Mortuary	213





Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

P·M·A
Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005

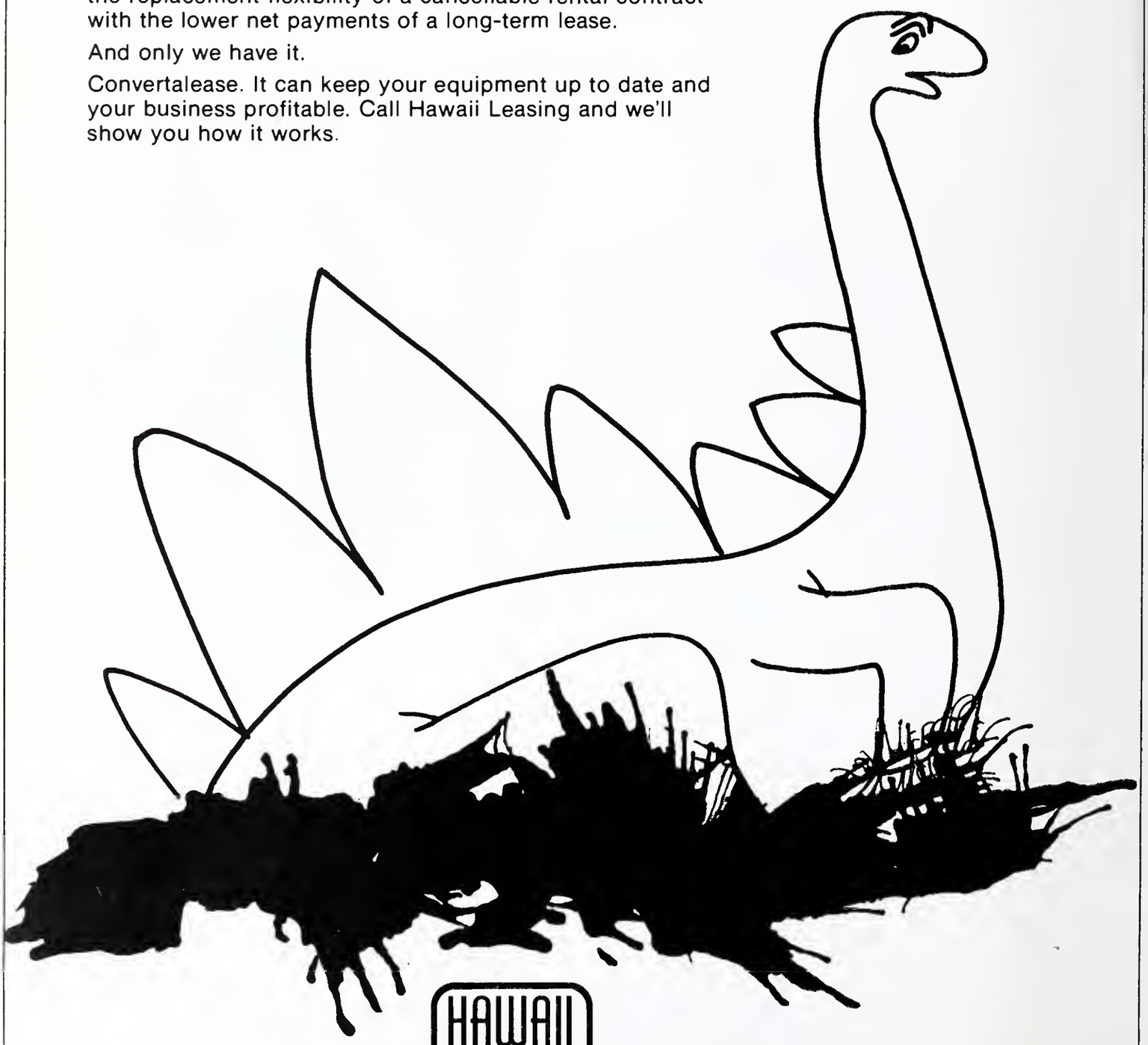
Obsolescence
...now it's obsolete

Equipment obsolescence and wear reduce efficiency and profit.

So it's important to replace equipment in time. But if you own equipment, you may not have recovered your investment through depreciation yet. And face it, we all tend to use something till it quits. Our answer is something that combines the replacement flexibility of a cancellable rental contract with the lower net payments of a long-term lease.

And only we have it.

Convertalease. It can keep your equipment up to date and your business profitable. Call Hawaii Leasing and we'll show you how it works.



Today's answer. HAWAII MEDICAL LEASING 700 Bishop St., Suite 902 • Honolulu, Hawaii 96813 • 546-2949

An activity of Amfac Financial

AUGUST, 1976
VOL. 35, NO. 8

Hawaii Medical Journal

CONTENTS

The Emergency Medical Service Program of Hawaii. Part II. Emergency Medical Technician (E.M.T.) Training of Hawaii's Ambulance and Rescue Personnel 227
J.K. Sims, M.D., Sandra Akina, R.N., B.S.N., Virginia Dods, R.N. and Livingston M.F. Wong, M.D.

Continuing Medical Education 235

Editorials 234

Hawaii Academy of Family Physicians' Newsletter 240

HMA Council Meeting 237

HMA Newsletter 233

News & Notes 242

The Library
Acquisitions Division SP
University of California, San Francisco
San Francisco California 94143

LIBRARY
U.C. SAN FRANCISCO
SEP 24 1976

Both often



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequenc and/or severity of grand mal seizures ma require increased dosage of standard anti convulsant medication; abrupt withdrawa may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and mus cle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium®
(diazepam) Ⓒ IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Estate planning. How long are you going to put it off?



It's the one thing people shy away from. And for no good reason, really. Take advantage of all the professional help you can get—right now. Like your accountant, your insurance agent, your attorney. And a First Hawaiian Bank trust officer.

Fact: First Hawaiian is the *only* full-service trust bank in Hawaii.

One of our trust officers will be happy to meet with you. He'll review your present situation. And ask for your thoughts and goals. Then we'll tailor an estate plan to your specific needs. At no charge.

Your Customer Consultant can arrange an appointment for you. Or call Joe Battista, Ken Nakamura or Herb Loomis in our Trust Division at 525-7051.

First Hawaiian Bank
the bank that says yes

MEMBER FDIC

HAWAII MEDICAL JOURNAL

Published Monthly by the
HAWAII MEDICAL ASSOCIATION
(Incorporated in 1856 under the Monarchy)
320 Ward Avenue, Honolulu, Hawaii 96814

EDITORS

Editor, HARRY L. ARNOLD, JR., M.D.
News Editor, HENRY N. YOKOYAMA, M.D.
Assistant Editor, DORIS R. JASINSKI, M.D., M.P.H.
Contributing Editor, ROBERT H. MOSER, M.D.
Contributing Editor, J.I. FREDERICK REPPUN, M.D.
Book Review Editor, WINFRED Y. LEE, M.D.
Executive Editor, PAUL STEWARD

OFFICERS

President, WILLIAM W.L. DANG, M.D.
President-Elect, CALVIN C.J. SIA, M.D.
Past President, WINFRED Y. LEE, M.D.
Secretary, R. VARIAN SLOAN, M.D.
Treasurer, GROVER H. BATTEN, M.D.

County Presidents

Hawaii, KENNETH HUGHES, M.D.
Honolulu, DOUGLAS B. BELL, II, M.D.
Kauai RIEAZI REMITIO, M.D.
Maui, CLIFFORD MORAN, M.D.
Delegate to AMA, GEORGE H. MILLS, M.D.
Alternate Delegate to AMA,
HERBERT Y.H. CHINN, M.D.

Advertising Representatives
National:
HAWAII MEDICAL ASSOCIATION
320 WARD AVENUE
Honolulu, Hawaii 96814
Phone (808)536-7702
Honolulu:
LILITH JURRY, Phone 946-0053

THE JOURNAL may not be held responsible for opinions expressed in papers, discussions, communications, or advertisements. The advertising policy of the HAWAII MEDICAL JOURNAL is governed by the rules of the Council on Drugs of the American Medical Association. The right is reserved to reject material submitted for editorial or advertising columns. All material for publication must be in the hands of the editor on or before the 10th day of the month preceding publication date. Reprints of original articles will be supplied at actual cost. A reasonable number of illustrations accompanying an article will be accepted for printing. The right is reserved to ask the author to bear cost of these when it is found necessary to do so.

Copyright 1976 by the Hawaii Medical Association, Honolulu, Hawaii. 2nd class postage paid at Honolulu, Hawaii. Office of Publication: 320 Ward Avenue, Honolulu, Hawaii 96814.

TAX SHELTER WITH PLAY!

JOCKEY CLUB

IN LAS VEGAS

Las Vegas' most beautiful condominium resort on the strip next to the Dunes—across the street from the MGM and the Alladin Hotel.

Compare your pluses:

Tax shelter
Maximum leverage
Entertainment capitol of the world
Many other advantages

Once-in-a-lifetime opportunity to own something of inestimable value under the most advantageous terms and conditions. Prices start from $48,000 cash or may be purchased at 10% down, 360 monthly payments of $332.17 at 8½% annual percentage rate. Condominium units may be placed in a rental program when not in use.

CENTURY PACIFIC, INC.
REALTORS

1027 A Bishop St. Honolulu
Ph. 521-6987

aggravating



...allergic dermatoses

with strong emotional overlay

Atarax®
(hydroxyzine hydrochloride)

TABLETS: 10 mg, 25 mg, and 50 mg

- rapid antianxiety action
- demonstrated antihistaminic activity

Contraindications: Hypersensitivity to hydroxyzine. Hydroxyzine, when administered to the pregnant mouse, rat, and rabbit, induced fetal abnormalities in the rat at doses substantially above the human therapeutic range. Clinical data in human beings are inadequate to establish safety in early pregnancy. Until such data are available, hydroxyzine is contraindicated in early pregnancy.

Precautions: Hydroxyzine may potentiate the action of central nervous system depressants such as meperidine and barbiturates. In conjunctive use, dosage for these drugs should be reduced. Because drowsiness may occur, patients should be cautioned against driving a car or operating dangerous machinery.

Adverse Reactions: Drowsiness may occur; if so, it is usually transitory and may disappear in a few days of continued therapy or upon dosage reduction. Dryness of the mouth may occur with higher doses. Involuntary motor activity, including rare instances of tremor and convulsions, has been reported, usually with higher than recommended dosage.

Supply: Tablets, containing 10 mg, 25 mg, or 50 mg hydroxyzine hydrochloride, 100's and 500's; Tablets, containing 100 mg, 100's; Syrup, containing 10 mg per teaspoonful (5 ml) and ethyl alcohol 0.5% v/v, pint bottles.

Before prescribing or administering, see package circular.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

One contains aspirin.
One doesn't.



Darvocet-N® 100

100 mg. propoxyphene napsylate
and 650 mg. acetaminophen

Darvon® Compound-65

65 mg. propoxyphene hydrochloride,
227 mg. aspirin, 162 mg. phenacetin,
and 32.4 mg. caffeine

Lilly

Additional information available to the profession on request.
Eli Lilly and Company, Inc., Indianapolis, Indiana 46206

500341

The Emergency Medical Services Program of Hawaii.* Part II. Emergency Medical Technician (E.M.T.) Training of Hawaii's Ambulance and Rescue Personnel

J. K. SIMS, M.D.,* SANDRA AKINA, R.N., B.S.N.,**
VIRGINIA DODS, R.N.,† and LIVINGSTON M.F. WONG, M.D.,†† *Honolulu*

• *A primary stimulus for the intensification of emergency medical care training for ambulance personnel in the U.S.A. arose from the 1966 publication of "Accidental Death and Disability: The Neglected Disease of Modern Society."*[1] *A jarring phrase from this publication was the feeling of several Korean War and Vietnam, consultants that "chances of survival would be better in the zone of combat than on the average city street."*[2]

To improve chances of survival on the average city street, the National Academy of Sciences—National Research Council specifically recommended "preparation of nationally acceptable texts, training aids, and courses of instruction for rescue squad personnel, policemen, firemen, and ambulance attendants."[3] Such texts, training aids, and courses of instruction, particularly for ambulance personnel, were rapidly developed,[1-10] and this new initial level of ambulance attendant training became known as "Emergency Medical Technician—Ambulance,"[8-10] or E.M.T. Training.

A job description "for the "emergency medical technician—ambulance" has been formulated by the National Registry of Emergency Medical Technicians, and the work requirements of this formulation indicates that the EMT: "responds to emergency calls to provide efficient and immediate care to the critically ill and injured, and transports the patient to a medical facility."[11] The E.M.T. also "determines the nature and extent of illness or injury and establishes priority for required emergency care. Renders emergency care, such as opening and maintaining an airway, giving positive pressure ventilation, cardiac resuscitation, controlling of hemorrhage, treatment of shock, immobilization of fractures, bandaging, assisting in childbirth, management of mentally disturbed patients and initial care of poison and burn patients."[11]

First Class in 1971

Emergency Medical Technician (E.M.T.) training programs rapidly spread throughout the U.S.A.[12] The Emergency Medical Services Program of Hawaii (HEMSP) implemented its first E.M.T. class in 1971.[13-15] The National Registry of Emergency Medical Technicians approved the EMT course of HEMSP for training Emergency Medical Technicnans in Hawaii.

This National Registry of Emergency Medical Technicians was established to provide the following specific objectives and services:[16]

1. To promote the improved delivery of Emergency Medical Services by:
 (a) Assisting in the development and evaluation of educational programs to train Emergency Medical Technicians

The Emergency Medical Service Program of Hawaii is a project of the Hawaii Medical Association.
The writing of this publication was supported by grant funds from the Department of Health, Education, and Welfare under Public Law 93-154.

* Training Coordinator, Emergency Medical Services Program (Hawaii), 1301 Punchbowl Street, Honolulu, Hawaii 96813; member, American College of Emergency Physicians.
** EMT Instructor, Emergency Medical Services Program (Hawaii).
† Training Instructor, Emergency Medical Services Program (Hawaii).
†† Director, Emergency Medical Services program (Hawaii); member, American Trauma Society.

Accepted for publication January, 1976.

(b) Establishing qualifications for eligibility to apply for registration
(c) Preparing and conducting examinations designed to assure the competency of Emergency Medical Technicians
(d) Establishing a system for biennial re-registration (every two years)
(e) Establishing procedures for revocation of certificates of registration for cause
(f) Maintaining a directory of Registered Emergency Medical Tech-

FIGURE 1.—*Classroom schedule for HEMSP's Emergency Medical Technician Training Program.*

WK I	MONDAY 11/3/75	TUESDAY 11/4/75	WEDNESDAY 11/5/75	THURSDAY 11/6/75	FRIDAY 11/7/75
8-9	WELCOME & ORIENTATION	INTRODUCTION: RESPIRATORY SYSTEM Lec. & slides	STERILE TECHNIQUE Lec. & Demo	BEHAVIOR DISORDERS Kaneohe State Hos.	EXAM # 1
9-9:15	coffee	coffee	coffee	coffee	coffee
9:15-10	ENT-PATIENT RELATIONSHIP Lec. & Discus.	Film: MECHANICS OF BREATHING	CHEST INJURIES Lec. & Slides		
10-11	MEDICAL TERM.. Pretest & Lec.	RESPIRATORY PHYSIOLOGY Lect.	SUCTIONING Lec., Demo. & Prac.		PRACTICAL EXAMS
11-12	lunch & study	lunch & study	lunch & study		lunch & study
12-1	DIAGNOSTIC SIGNS & SYMPTOMS Lecture	VITAL SIGNS Lecture	MANUAL VENTILATION Lec., Demo. & Prac.	LUNCH	DROWNING & NEAR-DROWNING Lect. & Slides
1-2	COURSE OVERVIEW (SIGNS & SYMPTOMS) Lecture	VITAL SIGNS Demo. & Pract.		FACIAL INJURIES Lect. & Slides	DIVING EMERGENCIES Lect. & Slides
2-3	MATH PRETEST & MATH REVIEW	RESPIRATORY PROBLEMS Lecture	TERM QUIZ #1	TERM QUIZ	CPR Lec., Demo. & Prac.
3-4	TOUR : QUEEN's HOSPITAL		REVIEW WORKSHOP	STERILE TECHNIQUE Practice	

WK II	MONDAY 11/10/75	TUESDAY 11/11/75	WEDNESDAY 11/12/75	THURSDAY 11/13/75	FRIDAY 11/14/75
8-9	INTRODUCTION: CARDIOVASCULAR SYST. Lec. & Slides	CARDIAC EMERGENCIES Lecture	12 LEAD EKG Lec., Demo & Prac.	EKG MONITORING Lec., Demo. & Prac.	EXAM II
9-9:15	coffee	coffee	coffee	coffee	coffee
9:15-10	Film: WORK OF THE HEART Discussion	Film: Room: "M.I."			
10-11	SHOCK-HEMORRHAGE PART I Lecture	SHOCK-HEMORRHAGE PART II Lecture	TERM QUIZ	BANDAGING Lec., Demo. & Prac	CPR AM. HEART. CERT. EXAMS
11-12	lunch & study	lunch & study	lunch & study	lunch & study	lunch & study
12-1	BASIC EKG Lec. & Worksheets	BURNS Lecture	HLR Lec., Demo. & Prac	SHOCK-ASSESSMENT PART III Lecture	
1-2					
2-3	BEEF HEART LAB. (CV Lab)	CPR (CPR Classroom) Lec., Demo. & Prac.	CPR PRACTICE (CPR Classroom)	TOURNIQUETS Lec., Demo. & Prac	
3-4				CPR PRACTICE	

WK III	MONDAY 11/17/75	TUESDAY 11/18/75	WEDNESDAY 11/19/75	THURSDAY 11/20/75	FRIDAY 11/21/75
8-9	Film: CNS EMERGENCY Discussion	COMMUNICABLE DISEASE Lecture	DIABETES Lecture	EMERGENCY MEDICAL DRIVING Lect., Demo. & Prac	EXAM III
9-9:15	coffee	coffee	coffee	coffee	coffee
9:15-10	NERVOUS SYSTEM ANATOMY & PHYSIOLOGY	PSYCHOLOGY - INTRODUCTION Lecture	Film: UNDERSTANDING DIABETES		
10-11	CNS EMERGENCIES Lect. & Slides		TERM QUIZ		RADIO COMMUNICATION Lec., Demo, Workaht
11-12	lunch & study	lunch & study	lunch & study	lunch & study	lunch & study
12-1	UNCONSCIOUS PATIENTS Lecture	Film: DRUG ABUSE	RESPIRATORY INF. DISEASES - O_2 EQUIPMENT	PRACTICAL EXAMS (Vent & HLR)	CHARTING Lecture & Worksheets
1-2	Film: INNER MORTU OF ARRASIA	DRUG ABUSE Lecture			
2-3	CVA SEIZURES Lecture	ELECTRICAL HAZARDS Lect. & Slides	DIABETES/ CVA Lecture		DANGEROUS HAWAIIAN MARINE ORGANISMS Lecture
3-4			POISONING Lecture		Film: VENOMOUS ANIMALS OF THE SEA

WK IV	MONDAY 11/24/75	TUESDAY 11/25/75	WEDNESDAY 11/26/75	THURSDAY 11/27/75	FRIDAY 11/28/75
8-9	EMERGENCY CHILD-BIRTH Lec.,Demo. & Prac.	CARE OF THE NEW-BORN Lecture	LEGAL ASPECTS Lecture	HOLIDAY	EXTRICATION PART I Lec.,Demo. & Prac.
9-9:15	coffee	coffee	coffee	coffee	coffee
9:15-10	Film: EMERGENCY CHILDBIRTH	TERMINOLOGY QUIZ	NEURO ASSESSMENT Lecture		
10-11	CARE OF THE MOTHER Lecture	ABDOMINAL INJUR-INJURIES Lecture			CODE REVIEW
11-12	lunch & study	lunch & study	lunch & study	lunch & study	lunch & study
12-1	FRACTURES Lec. & Worksheets	SPLINTING PART I Slides,Demo.& Pra	SPLINTING PART II (Continue)		EXAM # IV
1-2					
2-3		PEDIATRIC RESPI-RATORY EMERGEN-CIES	AUTOMOBILE ACCI-DENT INJURIES Lec. & Slides		PRACTICAL EXAMS (Sterile Technique
3-4	CHILD ABUSE Lec. & Slides	TOUR: CHILDREN's HOSPITAL		HOLIDAY	

WK V	MONDAY 12/1/75	TUESDAY 12/2/75	WEDNESDAY 12/3/75	THURSDAY 12/4/75	FRIDAY 12/5/75
8-9	EXTRICATION PART II - AUTO (Hickam AFB)	AQUATIC INJURIES ASSESSMENT Lecture	MULTIPLE TRAUMA Lecture	DISASTER: MAST Film & Demo (Tripler Army Hos)	FINAL EXAM
9-9:15	coffee	coffee	coffee	coffee	coffee
9:15-10		EXTRICATION PART III - WATER (Manoa Pool)			
10-11			SUICIDE Lec. & Discussion		
11-12	lunch & study	lunch & study	lunch & study		lunch & study
12-1		MEDICAL RECORDS Workshop	TERMINOLOGY QUIZ	Lunch & Study	CLINICAL ORIEN-TATION Tour Queen's Hos.
1-2			PEDIATRIC EMERGENCIES Lecture	CLINICAL EVALUA-TION (ER PATIENT) Practice	QUEEN'S ER ORIENTATION
2-3		REVIEW			ST. FRANCIS ER ORIENTATION
3-4			REVIEW	TOUR KAPIOLANI MATERNITY HOSP.	AMBULANCE ORIEN-TATION (at St. Francis)

nicians

2. To develop guidelines and programs to assist individuals who have completed Emergency Medical Technicians Programs to raise their level of competence to assure the provision of improved Emergency Medical Services, and
3. To do any and all things necessary or desirable for the attainment of the purposes stated above.

EMT courses approved by the registry are required to be at least 81 hours in length. The longer EMT course length of HEMSP was selected for three reasons: (a) provision of thorough training for ambulance personnel in their initial emergency medical care course in Hawaii (a number of personnel had no formal emergency training in the past); (b) desirability to use the EMT course as one step toward training ambulance paramedics; (c) the long patient transport distances found in some parts of Hawaii between the scene of the emergency and a hospital emergency facility (this makes in-depth training a necessity for adequate patient management en route).

Where EMTs Come From

The general stipulations of HEMSP for entering the EMT training course included that the prospective student be an employed ambulance attendant or rescue squad specialist (or a firefighter in an emergency medical care delivery situation) from any of the following agencies: the Ambulance Department of the City & County of Honolulu, the Honolulu Fire Department Rescue Squad, the Hawaii County Fire Department, the State Department of Health hospital-ambulance units (on any island), the Hickam Fire Rescue Squad (covering both Hickam Air Force Base and the Honolulu International Airport), any private ambulance company (on any island), any contract ambulance company (on any island). Student selection does not depend on age, sex, marital status, religion, ethnic origin, height/weight, level of education attained, prior to first-aid training, physical strength, or prior emergency medical care training.

The HEMSP 400-hour EMT course is divided into two equal portions: 5 weeks classroom (8:00 a.m. - 4:00 p.m. Monday through Friday) and 5 weeks clinical (40 hours per week). Representative schedules for these initial five weeks of train-

ing comprise Table 1. The lectures, discussion sessions, practice sessions, field trips, hospital tours, and exams are conducted by physicians, nurses, lay specialists, or ambulance paramedics during the "classroom" portion of the training period. The time breakdown on topics covered during these first five weeks is shown in Table 2.

FIGURE 2.—*Emergency Medical Technician Training topics and hours.*

TOPIC	# HOURS
• Orientation	1
• Cardiopulmonary Resuscitation	12
• Signs, Symptoms, Vital Signs	6
• Trauma	10
• Bandaging, Splinting, Tourniquets	6
• Shock (4), Burns (2)	6
• Cardiocirculatory Anatomy, Physiology, & Electrocardiography	10
• Cardiac Emergencies & Heart-Lung Resuscitator	4
• Respiratory Anatomy & Physiology	3
• Respiratory Emergencies	4
• Sterile Technique, Suctioning, Ventilation, Oxygen Therapy	4
• Neurological Anatomy, Physiology, & Examination Techniques	3
• Neurological Emergencies	6
• Aquatic Emergencies	7
• Psychiatry	9
• Auto Extrication	10
• Obstetrics & Pediatric Emergencies	7
• Communications, Medical Driving, & Disaster	14
• Medical Emergencies	6
• Integrative Review	3
• Tours	16
• Quizzes & Exams	15
• Practical Exams	5

The differential use of lectures, slides, films, exams, practice sessions, field trips, hospital tours is noted in Table 1, and covers the range of psychiatric, obstetrical, surgical, medical, neurological, diving, pediatric and orthopedic emergencies. EMT students in the classroom learn about anatomy, physiology, patient assessment, and pathophysiology, plus specific interventive techniques to be applied during emergencies.

The cardiopulmonary resuscitation (CPR) taught is the Basic Life Support course of the American Heart Association,[17] and successful certification in Basic Life Support is required in order to pass the EMT course. Other skills taught include oro-pharygno-naso-tracheal suctioning, use of the heart-lung mechanical resuscitator, bandaging, splinting, aquatic extrication (for aquatic spinal injury), automobile victim extrication, airway use, bag-mask ventilation, positive pressure oxygen-enriched ventilation, tourniquet application, vital signs monitoring, cardioscope EKG monitoring for rate and rhythm, baby delivery, sterile technique, and acute burn care.

Practical Exams

In-course practical exams are administered to insure students' proficiency in each of these areas. The ambulance EMT trainees are also given instructions in Motorola Coronary Observation Radio Communications (for verbal and EKG telementry), emergency medical driving, and ambulance report form charting. The medicolegal implications of emergency medical care are discussed throughout the course and as a separate lecture.

Field trips are made to the Pearl Harbor Diving Recompression Center, the Children's Hospital Pediatric Pulmonary Center, the Hawaii State Hospital (psychiatric) at Kaneohe, the Tripler Army Medical Center, MAST Medical Evacuation Unit (68th MEDEVAC), Kaiser Hospital Emergency Room (E.R.), the Queen's Medical Center E.R., St. Francis Hospital E.R., and Kapiolani Hospital (obstetrics & gynecology). This helps provide ambulance personnel with an orientation to patient care destinations, an overview of the continuity of emergency medical care delivery, and identification of subsequent sites for learning during the clinical phase of training.

The second five weeks of EMT training is strictly clinical, wherein the 15 EMT trainees are provided opportunity to apply skills learned in the classroom to patient situations. The majority of these 200 hours are spent by EMT trainees under the direct supervision of the delivery room nurses, emergency room nurses, emergency physicians, and the ambulance paramedics (ie, under the supervision of the *M*obile *I*ntensive *C*are *T*echnicians or M.I.C.T.'s). This clinical training is somewhat like on-the-job training. However, the EMT trainees are still directly responsible to the EMT instructor on a one-to-one basis through required weekly case history reports (on patients treated or transported) and procedures reports (*eg*, gastric lavage for certain types of poisoning).

The EMT instructor visits each of the ambulance units or emergency rooms to which EMT trainees are assigned in order to evaluate their progress. The EMT trainees are strongly encouraged to follow up on their patients who are admitted to a hospital, and the EMT instructor periodically visits these patients in the hospital with the EMT trainee. The other primary exposure to in-hospital patients that the EMT trainee receives during the clinical experience is on a one-day assignment to an obstetrical labor and delivery room. This extends the EMT trainee's experience for the emergency delivery of babies.

EMT trainees are given several written and oral quizzes (accountable for grade points) each week during the first five weeks. Trainees also take an examination at end of each week for the first five weeks. At the end of the ten week course, the EMT trainees are given final exams to re-assess their proficiency. Overall course grading is 50% didactic and 50% performance (practical exams = 25 points; clinical assignments = 5 points; and clinical performance = 20 points). Those passing the ten week EMT course are generally adept at the following skills (see Table 3):

a) naso-oro-pharyngo-trachael suctioning,
b) Basic Life Support Cardiopulmonary resuscitation,
c) bandaging,

FIGURE 3.—*Emergency Medical Technician (EMT) skills.*

- Cardiopulmonary Resuscitation (Basic Life Support[17])
- Obtaining Pertinent Patient History (abbreviated)
- Performing Pertinent Physical Exam (abbreviated)
- Obtaining & Monitoring Vital Signs
- Establishment & Maintenance of Airway
- Relief of Accessible Acute Respiratory Obstructions
- Suctioning (Oral, Nasal, Pharyngeal, Tracheal)
- Administration of free-flow 100% Oxygen
- Ventilation with Bag-Mask Apparati
- Ventilation with Positive Pressure 100% Oxygen (Elder-type Valve)
- Application & Use of Mechanical Automatic Heart-Lung Resuscitator
- Control of Hemorrhage
- Bandaging
- Application of Tourniquet
- Immobilization or Splinting of Fractures/Dislocations/Sprains
- Application of Arm Slings
- Immobilization-Extrication of Selected Automobile Injury Victims
- Immobilization-Extrication of Aquatic Spinal Injury Victims
- Performance of Light Rescue Services[11] and Triage
- Emergency Delivery of Baby
- Observance of Sterile Technique
- Oscilloscopic Monitoring of EKG Rate & Rhythm
- Operation of Coronary Observation Radio (radiotelemetry unit)
- Operation of Emergency Medical Vehicle (as course-trained)
- Documents Patient Care on Standardized Ambulance Report Form[15]
- Communication of Patient Care Data to Recipient Physicians/Nurses
- Pre-Hospital First Aid for Venomous Marine Organism Injuries
- Non-pharmacological Management of Shock, Poisoning, Cardiopulmonary Arrest, Diabetic Emergencies, Acidosis, & Cardiac Arrhythmias

*for EMT's trained by HEMSP

d) splinting (cardboard, air-inflatable, Thomas, Hare-Traction),
e) vital signs monitoring,
f) taking an abbreviated concise history,
g) taking an abbreviated concise physical examination,
h) airway creation and maintenance,
i) mechanical CPR application and use via Heart-Lung Resuscitator,
j) nasal cannula or mask free-flow oxygen administration,
k) positive-pressure (eg, Elder-type valve) mask oxygen insufflation,
l) emergency baby delivery,
m) hemorrhage control,
n) non-pharmacologic management of cardiopulmonary arrest,
o) non-pharmacologic management of shock,
p) water immobilization-extrication for aquatic cervical injury,
q) automobile immobilization-extrication for traffic victims,
r) non-pharmacologic resuscitation for near-drowning,
s) administration of simplified therapy for venomous marine organisms,
t) communication with emergency physicians and nurses,
u) data recording on patient ambulance report form (computerized)

After students satisfactorily complete the EMT course of HEMSP, they are eligible to take the EMT National Registry Examination. This is a nationwide computer-scored written and locally-scored practical examination offered by the National Registry of Emergency Medical Technicians. Those EMTs passing both parts of the EMT National Registry Exam are then classified as certified EMTs and their names are kept on a national computer file by the National Registry of Emergency Medical Technicians. As of August 1, 1975, HEMSP had trained 216 EMTs and 136 (63%) had become certified EMTs by passing the EMT National Registry Examination.

Hilo Courses Offered

Since May, 1975 the Hawaii State Department of Health has offered approved EMT courses in Hilo, Hawaii, and by January, 1976, trained 12 EMTs, with four becoming certified EMTs.

Despite the 400 hour EMT course and the EMT National Registry Exam, the EMT (ie, EMT-basic) and the certified EMT are not authorized by the Hawaii State Board of Medical Examiners or HEMSP to perform any of the following:

a) cardiac electrical defibrillation,
b) intravenous cannulization,
c) administration of medications by subcutaneous, intramuscular, or intravenous routes),
d) nasogastric tube insertion,
e) gastric lavage,
f) endotracheal or nasotracheal intubation,
g) cricothyroid puncture,
h) closed chest needle thoracostomy,
i) interpretation of EKG's,
j) rotating tourniquet application.

The above techniques may, however, be performed by ambulance paramedics (ie, MICT's or Mobile Intensive Care Technician) upon orders from a physician.

Continuing education is an integral part of the HEMSP plan for EMT's. Phase I consisted of 24 hours of training over 3 days in anatomy-physiology review, shock refinement, neurological assessment, diabetes, patient assessment, heart-lung resuscitator retraining, and recertification in Basic Life Support CPR. A minimum of 24-40 hours of EMT Continuing Education retraining may be required annually.

Emergency Medical Technicians are an important part of emergency medical care delivery. EMT's, with the training they now possess, have been reported[18] to perform much better than the former Red Cross course-trained ambulance personnel and even better than at-scene physicians and nurses.

Acknowledgements

1. Manuscript typing—secretarial staff of the Hawaii Emergency Medical Services Program.
2. Assistance with literature search—staff of the Hawaii Medical Library.
3. Lecturing to EMT classes—the many dedicated physicians, nurses, and lay persons in Honolulu.
4. Host teaching facilities (our deepest appreciation)

 Queens Medical Center
 St. Francis Hospital

Kaneohe State Hospital
Kapiolani Hospital
Children's Hospital

Kaiser Medical Center
Pearl Harbor Recompression Center
Tripler Army Medical Center

REFERENCES

1. Committee on Trauma and Committee on Shock, Division of Medical Sciences, National Academy of Sciences—National Research Council: *Accidental Death and Disability: The Neglected Disease of Modern Society.* Washington: NAS-NRC, 1966, 38 pp.
2. *ibid.* p. 12.
3. *ibid.* p. 13.
4. *Training of Ambulance Personnel and Others Responsible for Emergency Care of the Sick and Injured at the Scene and During Transport.* Washington: US Government Printing Office, 1968, 23 pp.
5. Farrington JD: Community Training Program for Ambulance Attendants. *Bull Amer Col Sur* 53: 178-179, 186, 1968.
6. Farrington JD, Hampton OP: A Curriculum for Training Emergency Medical Technicians. *Bull Amer Col Sur* 54:273-276, 1969.
7. Committee on Injuries, American Academy of Orthopedic Surgeons: Emergency Care and Transportation of the Sick and Injured. *Amer Acad Ortho Sur* Chicago, 1971, 293 pp.
8. U.S. Dept. of Transportation, National Highway Safety Bureau: *Basic Training for Emergency Medical Technician–Ambulance: Course Guide and Course Coordinator Orientation Program.* Washington: US Government Printing Office, 1969, 40 pp.
9. U.S. Dept. of Transportation, National Highway Safety Bureau: *Basic Training Program for Emergency Medical Technician–Ambulance: Concepts and Recommendations.* Washington: US Government Printing Office, 1969, 45 pp.
10. U.S. Dept. of Transportation, National Highway Safety Bureau: *Basic Training Program for Emergency Medical Technician–Ambulance: Instructor's Lesson Plans.* Washington: US Government Printing Office, 1970, 243 pp.
11. U.S. Dept. of Transportation, National Highway Traffic Safety Administration: Job Description—Emergency Medical Technician—Ambulance. US Government Printing Office, 928-297. May, 1972. Reprinted by National Registry of Emergency Medical Technicians, 1395 E Dublin-Granville Road, Columbus, Ohio.
12. See: Hospital Literature Index (American Hospital Association, 840 N. Lake Shore, Chicago; published quarterly) under "Ambulance Service" or "Transportation of Patients" headings, since *Index Medicus* and MEDLINE searches abstract only a small % of available articles on this topic.
13. Chinn HYK: Emergency Medical Services—Hawaii. *Hawaii Med J* 32:240, 1973.
14. Chinn HYK: Emergency Medical Services Program. *Hawaii Med J* 33:477-479, 1974.
15. Sims JK, Wright LM, Gavin JA, et. al.: The Emergency Medical Services Program of Hawaii. I. General Overview. *Hawaii Med J* 35:49-51, 1976.
16. National Registry of Emergency Medical Technicians. Information and Qualifications for Registered EMT-Ambulance and Registered EMT-(Non-Ambulance). 1395 E. Dublin-Granville Road. P.O. Box 29233. Columbus, Ohio, 43229. February, 1974.
17. American Heart Association, National Academy of Sciences—National Research Council: Standards for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiac Care (ECC). JAMA supplement 227:833-868, 1974 (Feb 18).
18. Cronin K, Benson D, Rogers K: First Aid and Emergency Care Training: Its Effect on Pre-hospital Emergency Care. *J Amer Col Emerg Phy* 4:309-312, 1975.



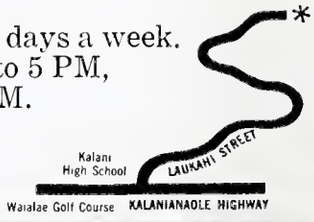
LAST OF ITS KIND IN THIS AREA!

Here "at the top . . ." overlooking the grandeur of the valley and sea below is a lifestyle that's second to none. To top it off, Waialae Iki IV is your last chance to custom build and assure a sweeping view from Diamond Head to Koko Head. Your architect or ours, your home design or ours, or a combination of ideas . . . let's talk about your home on the hill in Waialae Iki IV.

From **$163,400** including heated pool. Leasehold.

Model home open 7 days a week. Weekends, 10 AM to 5 PM, Weekdays, 1 to 5 PM.

New models with heated pools soon to be constructed.



WAIALAE IKI IV

Herbert K. Horita Realty, Inc. Kalihi Phone: 847-4241/Waimalu Phone: 487-1561/Waikiki Phone: 922-3377



H. Tom Thorson

Sagebrush Sam says the Philadelphia disease is simple—the little men from Mars resent the Viking Lander and took a shot at Washington—unfortunately they missed and hit Philadelphia.

Malpractice Insurance still a real problem. As this is written draft copies of the rules and regs are being drawn relating to the self-insured provider. Hearings are scheduled for August 16, with the Honolulu County Medical Society holding a special meeting on August 17. As things develop, more and more problems crawl out of the woodwork and HMA is continuing to plan to file suit questioning the constitutionality of the statute.

Questionnaire from the Department of Regulatory Agencies relative to your financial responsibility is pretty self explanatory. If you have a problem qualifying, be sure to request a hearing. The administrative procedures act provides that a professional license may not be revoked or renewal denied without giving the holder a chance to be heard. Take advantage of that process!

Flu Vaccine and liability for it still before congress. (Liability Bill Passed.)

AMA pursuing question of constitutionality of planning law with suit being held in North Carolina.

HMA will move to new headquarters at 320 Ward Avenue over the week end of August 21-22. There will be some confusion and no doubt some stumbles in the process. Please be a little patient until we get settled in. Telephone numbers will be the same as they have been.

HMA Annual Meeting is well along in planning. Scientific program and Continuing Education sessions under the direction of Dr. Tom Whelan are of exceptional quality.

Medical-Legal Inter-Professional Code provides for prompt payment to the physician for expert testimony and for the preparation of reports as well as for examinations. The responsibility for the payment is that of the attorney. Agreement should be reached before the event relative to the amount of payment and statements should be rendered promptly. Each member of HMA has been provided with a copy of the code and we suggest that you refer to it for details. (It's 5"x8" and blue.)

Confidentiality is going to be a big question. As areas of conflict increase, medical records become more and more a turning point. Physicians should look with a critical eye at "shotgun" requests for "all medical records". The authorization should be specific.

Council endorses Jon Won as Executive Director "Designate" to succeed Tom Thorson who will retire as of December 1, 1976.

Leukemia Society announces post-doctoral grants for research in leukemia and allied diseases. Grants will range from $25,000 to $100,000 to qualified researchers. Further information can be obtained from Dr. Rose Ruth Ellison, Leukemia Society of America, Inc., 211 East 43rd St., New York, N.Y. 10017. Deadline is October 1, 1976.

DSSH has encountered a problem that can be difficult to handle. They find it impossible to process the volume of applications for assistance within the regular time limits. As a result they are issuing letters to the applicants advising them of the delay as well as letter directed to the providers of service stating that the individual is an applicant and if the application is approved, payment will be made for services rendered. We presume if the applicant is denied, payment will not be made.

Work Opportunities—Medical Officer (Pediatrics) with Air Force. Full time civil service position. Direct inquiries to Civilian Personnel Office, 15 Air Base Wing/DPCC. Hickam AFB, Hawaii 96553, telephone 449-6733.

GP wanted to perform modest work for modest compensation. Join two GPs in Kamuela on the Big Island. Contact S.P. Gingrich, M.D., Box 248, Kamuela, Hawaii.

Office Space—Downtown Kailua, 35 Kainehe St., 1060 square feet at 66¢, plus pass-through.

Contact Kam Medical Supplies, Jay Tashima, Phone 537-5594.

LUCY HENRIQUES MEDICAL CENTER, Kamuela, Hawaii, has office space available. Contact Mark Sperry, Box 1108, Kamuela, Hawaii 96743.

Special Services—Pacific Rehab Center offers free swimming classes on Saturdays for handicapped children. Sponsored by Red Cross. If you have a patient needing such help, contact Leatrice Yamamoto, 546-3178 or 941-2852. Hawaii Heart Association will sponsor detection program for children with possible A Beta hemolytic streptococcus positive cultures and refer them for treatment. Program endorsed by the HMA School Health Committee.

MEETINGS—MEETINGS—MEETINGS!

Virgin Islands Medical Society second midwinter clinical conference will be held at the Buccaneer Hotel, St. Croix By The Sea Hotel, in St. Croix, V. I. January 13, 14, 15, 1977. Registration limited, 14 hours category I credit. Contact James S. Glenn, M.D., Chairman, U. S. Virgin Islands Medical Society, P. O. Box 520, Christiansted, St. Croix, U. S. Virgin Islands 00820.

International Medical Corporation will sponsor a meeting in Montreux, Switzerland. November 3-6, 1976. Subject matter on detection and evaluation of coronary disease. Contact P. Michael Hazel, International Medical Corporation, One Inverness Drive, Englewood, Colorado 80110.

District of Columbia Medical Society will hold a session on "Research and the Practice of Medicine in 1976" at the Sheraton Park Hotel Washington, D.C., September 16-18, 1976. Contact Miss Bess Custer, Medical Society of D.C., 2007 Eye St., N.W., Wash., D.C. 20006.

American College of OB & GYN, District VIII, will meet in Phoenix, Arizona, October 10-14, 1976. Of special interest is that HMA members will take office, Ralph W. Hale, M.D., as Section Chairman Elect, and Francis M. Terada, M.D., Section Vice Chairman Elect for Hawaii. Contact Donald F. Richardson, American College of OB & GYN, One East Wacker Drive, Chicago, Illinois 60610.

Something New—County Society Team Championship Trophy for the winning team designated by County Society Presidents in the HMA Golf Tournament. Permanent trophy donated by Tom Thorson.



We're on the wrong track!

It is too easy to forget that physicians owe their primary allegiance to their patients in hospital; medical staff work comes second. Staff work is the tail and it should not wag the dog.

Recently, at one of our local hospitals, a former JCAH inspector was asked to come in to the medical staff and advise in a dispute over voting rights within that organizational unit. He came by invitation extended to him by both the Medical/Dental Staff and the hospital's governing body: The Board of Trustees.

His visit was an exercise in futility. Perhaps reflecting the traditional attitude of the JCAH, and also the influence of the DHEW and its PSRO on the JCAH, he expounded repeatedly and at great length on the benefits of the medical audit and of peer review; how it was only in this way that medical practice could be improved—as if it was the corporate hospital that was practicing medicine.

Both the DHEW and the JCAH have fallen into this quicksand.

No amount of medical audits on the basis of surveying one or more disease entities, or procedures in hospital, will resolve the problem of a physician whose work is not up to par. Such busy-work may well be of academic interest and, therefore, of educational value. It does not necessarily follow that the aberrant physician will become educated and will mend his substandard ways. Such devious approaches by the M/D Staff do nothing but harass the busy other practitioners on that staff, those who are caring for their patients properly and well. The aberrant physician, meanwhile, either fails to participate in the audits, sleeps through the hortatory sessions, or goes on his merry way unperturbed.

This mandatory (imposed on us by both DHEW and the JCAH, its handmaiden) busywork is usually and cleverly passed on to the medical librarians by the "too busy" physicians.

This adds considerably to the burden of the former, an administrative department of the hospital, and often increases the costs of the administration, which equates with the increase of health care overall. The basic principle is a mankind-old ploy: It is too embarassing to undertake direct confrontation and accusation; it can be avoided by spreading over everyone in proximity the blanket of new rules and regulations under the anonimity of a committee!

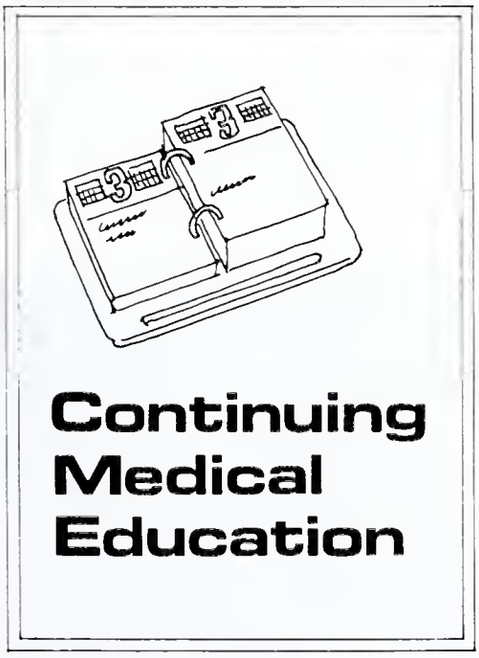
It rarely works.

Most hospital By-laws are filled with paragraphs that are in restraint of good patient care, their best intentions to the contrary not withstanding. Documentation is a fine word, but a rapid saving of a patient's life, for example, is infinitely more important than the documentation of the methodology. It is the outcome that counts, that is THE criterion as far as the patient is concerned. Documentation is all well and good, but we must not lose our perspectives by sacrificing the former for the latter. The DHEW more than our own JCAH, we're happy to note, cares less for outcome than it cares for the window-dressing medical audits that mostly prove nothing we didn't know already and that take up valuable space in "file thirteen".

In this day and age of physicians being overwhelmed by the masses of demanding patients on our doorsteps, let's not waste time ruminating that which has already been done, and, let's be forthright enough to tell off both the DHEW and the JCAH!

We never did get the voting rights dispute resolved!

J.I.F.R.



CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m.

Kaiser Hospital

(Contact CME Dept. for further information)

Kauikeolani Children's Hospital

1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program

Kapiolani Maternity Hospital

1. Grand Rounds, Wednesdays, 7:30-8:30 a.m.
2. Resident Conference, Tuesdays (except 1st), 1:00 p.m.
3. Ob-Gyn Department Meeting, 1st Tuesday, 1:00 p.m.
4. UH Seminars, Wednesdays, 3:30 p.m.
5. Perinatal Conference, Thursdays, 3:30 p.m.
6. Tumor Board, 1st & 3rd Fridays, 1:00 p.m.
7. Oncology Conference, 4th Friday, 1:00 p.m.
8. Visiting Professor Program

Kuakini Hospital

1. Hematology Rounds, Monday, 1:00-2:00 p.m.
2. Gastroenterology, Tuesday, 8:00-9:00 a.m.
3. Oncology Conference, Thursday, 8:00-9:00 a.m.
4. Endocrine Conference, 2nd Wednesday each month, 1:00-2:00 p.m.
5. Medical Statistics, 3rd Tuesday each month, 1:00-2:00 p.m.
6. Renal Conference, Wednesdays, 1:00-2:00 p.m.
7. Visiting Professor Program
8. Infectious Disease Conference, Thursdays, 1:00 p.m.

The Queen's Medical Center

(Contact Medical Staff Office for further information)

St. Francis Hospital

1. Medical Grand Rounds, Tuesdays (4th & 5th), 1:00-2:00 p.m.
2. Surgical Grand Rounds, Fridays (except 4th), 7:30-8:30 a.m.
3. Tumor Conference, Mondays, 7:30-8:30 a.m.
4. Visiting Professor Program
5. Clinical Pathology Topics, Mondays, 10:00-11:00 a.m.
6. Microslide Conferences, Tuesdays, 8:30-9:30 a.m.
7. Bone Marrow Pathology, Tuesdays, 2:00-3:00 p.m.
8. Basic Science Review & Research Conference, Thursdays, 1st & 3rd, 8:00-9:00 a.m.
9. Psychiatric Case Conference, Tuesdays & Fridays, 8:00-9:00 a.m.
10. Psychiatry for the Non-Psychiatrist, Tuesdays, 10:00-11:00 a.m.
11. Psychiatry Teaching Rounds, Thursdays, 9:00-10:00 a.m.
12. Medical Psychiatric Joint Teaching Rounds, Fridays, 11:00-12:00 noon
13. Surgical Mortality & Morbidity Conference, last Friday, 7:30-8:30 a.m.
14. Saturday Teaching Rounds, Saturdays (except 4th), 7:30-8:30 a.m.

Straub Clinic & Hospital

1. Medical Grand Rounds, first Thursday, 7:00 a.m.
2. Surgical Mortality & Morbidity, 4th Thursday, 7:00 a.m.
3. Quarterly Professional Staff Meetings, (Jan., Apr., Aug., Nov.), 4th Monday, 7:30 p.m.

Wahiawa General Hospital

1. Noon Seminars, 2nd Friday & 4th Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:30 p.m. & 2nd Wednesday, 12:30 p.m. of each month in the Mabel Smyth Building. Contact HMA Office as dates are subject to change.

Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817
At: Honolulu County Medical Society and Local Hospitals, Honolulu
Type: I, 1 hr/day, 1 day/mo from 12 mos
Fee: None Methods: AV, O, Pan
Dates: All yr, 12 hrs instruction

Telephone Task Force—Hawaii (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817
Type: I, 1 hr/day, 1 day/mo for 8 mos
Fee: None Methods: AV, Clin C, O, Pan, R
Dates: Arranged; 8 hrs instruction

SPECIAL EVENTS

August 23-24 — USC Course on the islands of Kauai and Maui at the Kauai Surf and Royal Lahaina Hotel respectively; 7:30 a.m.-12 noon. Registration fee unknown. For further information contact Phil R. Manning, M.D., University of Southern California, School of Medicine, 2025 Zonal Avenue, Los Angeles, Calif. 90033.

August 28-September 6 — Therapeutics Update sponsored by Postgraduate Education for Physicians in cooperation with the University of California in San Francisco; Maui Surf Hotel; 8:30-11:30 a.m.; Tuition $100; 15 hours Category 1 credit. For further information contact Barry S. Ramer, M.D., Daman-Nelson Travel, 115 Mission Street, San Francisco, California 94105.

Sept. 2, 1976-Aug. 4, 1977 — Telephone Task Force—Kauai (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817
Type: I, 1 hr/day, 1 day/mo for 12 mos
Fee: None Methods: AV, Clin C, O, Pan, R
12 hrs instruction.

Sept. 15-17 — Pediatric Nephrology, presented by the Department of Pediatrics of the University of Hawaii School of Medicine and Kauikeolani Children's Hospital at the Princess Kaiulani Hotel. Tuition is $40.00; registration is required; 16 hours credit. Contact: Sherrel L. Hammar, 226 North Kuakini Street, Honolulu 96817.

Sept. 11-18 — Practical Management of Anesthesia Problems (#105) University of Southern California School of Medicine, 2025 Zonal Avenue, Los Angeles 90033
At: Mauna Kea Beach Hotel, Kamuela, Hawaii
Of interest to: Anesthesiologists
Approximate # hours: 25
Faculty Coordinator: Judson Denson, M.D. Professor of Anesthesiology (Chairman)
A course designed for anesthesiologists to give adequate time to discuss the important aspects of anesthesia practice.

Sept. 23, 1976-Aug. 25, 1977 — Telephone Task Force—Maui (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817
Type: I, 1 hr/day, 1 day/mo for 12 mos
Fee: None Methods: AV, Clin C, O, Pan, R—12 hrs instruction.

Sept. 25-Oct. 1 — Cardiology—1976 (#120) University of Southern California School of Medicine, 2025 Zonal Avenue, Los Angeles 90033
At: Mauna Kea Beach Hotel, Kamuela, Hawaii
Of interest to: Internists, Cardiologists
Approximate # hours: 25
Coordinator: Willis Hurst, M.D., Professor & Chairman, Department of Medicine, Emory University
This week is designed to bring the internist and cardiologist up-to-date in current problems of cardiology.

October 3-8 — VI Asian Pacific Congress of Cardiology at the Sheraton-Waikiki; contact Dr. Morton Berk for further information at 537-2211.

Oct. 18-22 — American College of Physicians—Hormonal Aspects of Internal Medicine; Ilikai Hotel; Director John Kim, M.D. Credit 19½ hours

Is the diagnosis ALCOHOLISM?

Time proven alcoholism treatment — formerly available only at Mainland centers — now offered at Post Hospital Recovery Unit, Hilo Care Center.

- A basic, 28-day in-patient program of motivational counseling
- Therapists carefully selected and themselves recovered alcoholics
- Hawaii licensed professional consulting staff in psychiatry, psychology and family medicine
- Privacy, seclusion, total confidentiality in modern facility, beautiful setting

Direct inquiries to:
Marilee Fletcher, Associate Director,
Post Hospital Recovery Unit,
HILO CARE CENTER
944 West Kawailani Street
Hilo, Hawaii 96720 Phone (Hilo) 959-9151

Category 1. Contact: Registrar, ACP, 4200 Pine St. Philadelphia, Pa. 19104

Oct. 25-29 — Hawaii Medical Association Annual Meeting: Ilikai Hotel: contact Bess Chang for further information at 536-7702.

Oct. 26 — Fireside Conference (B) Hawaii Thoracic Society, 245 N. Kukui St., Honolulu 96817
Co-sponsor: American Lung Assn. of Hawaii
At: Ilikai Hotel, 1777 Ala Moana, Honolulu 96815
Type: C, 1 day Fee: None
Methods: AV, Lec, O, Pan 2½ hrs instruc.

Oct. 26-Nov. 2 — Visiting Professorship Program (B) Hawaii Thoracic Society, 245 N. Kukui St., Honolulu 96817. Co-sponsor: American Lung Association of Hawaii
At: Major hospitals on Oahu, Kauai, Maui & Hawaii
Type: CC Fee: None
Methods: AV, BR, Lec, O 6 hrs instruction

Oct. 30-Nov. 6 — Evaluation of Neoplastic Lymphoproliferative Disorders University of Southern California School of Medicine, 2025 Zonal Ave., Los Angeles 90033
At: Hawaii—Mauna Kea Hotel, Mauna Kea
Type: C, 7 days 42 hrs instruction

Nov. 17-24, 1976 & March 13-19, 1977 — Diving Medicine (B-50) Undersea Med. Soc., c/o Professor Edward Beckman, University of Hawaii Conference Center, 1960 East-West Road, Honolulu, 96822
At: Kailua Kona
Type: C, 8 days Fee: $200
Methods: AV, OP, PP, Lec, O, Sem 25 hrs instruction

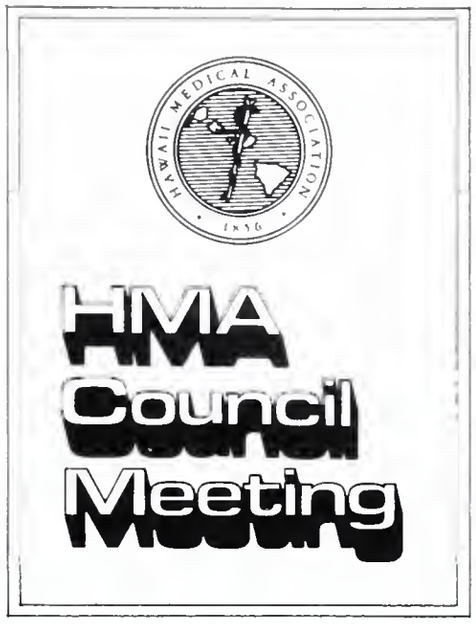
The seminars on "Sexual Counseling: Office Management of Sexual Problems" sponsored by the ACOG and University of Hawaii will be held on the following dates: (20 hrs. credit)

October 18-22 December 20-24
November 22-26

For further information, write to: American College of Obstetricians & Gynecologists, Department of Continuing Education, 1.E. Wacker Drive, Suite 2700, Chicago, IL 60601

OUT OF STATE

For information on any out-of-state programs or courses, refer to August 11, 1975 Supplement to JAMA or call the HMA Office.



Friday, May 28, 1976, 5:30 P.M.
Mabel Smyth Lanai

CALL TO ORDER

The meeting was called to order by President William W.L. Dang. Also present were Drs. Calvin C.J. Sia, R. Varian Sloan, Grover H. Batten, George H. Mills, Ann B. Catts, Albert Chun-Hoon, George Goto, Carl Lum, J.I.F. Reppun, Arnold Siemsen, Sakae Uehara, Peter Kim, Douglas Bell II, Clifford Moran, and Kenneth Hughes. Dr. Roy Kuboyama was seated as councillor pro tem for Dr. Lichter. Also present were Dr. Ronald Hattis, Mrs. Dorothy Shepard, and Dr. Thomas Whelan.

MINUTES

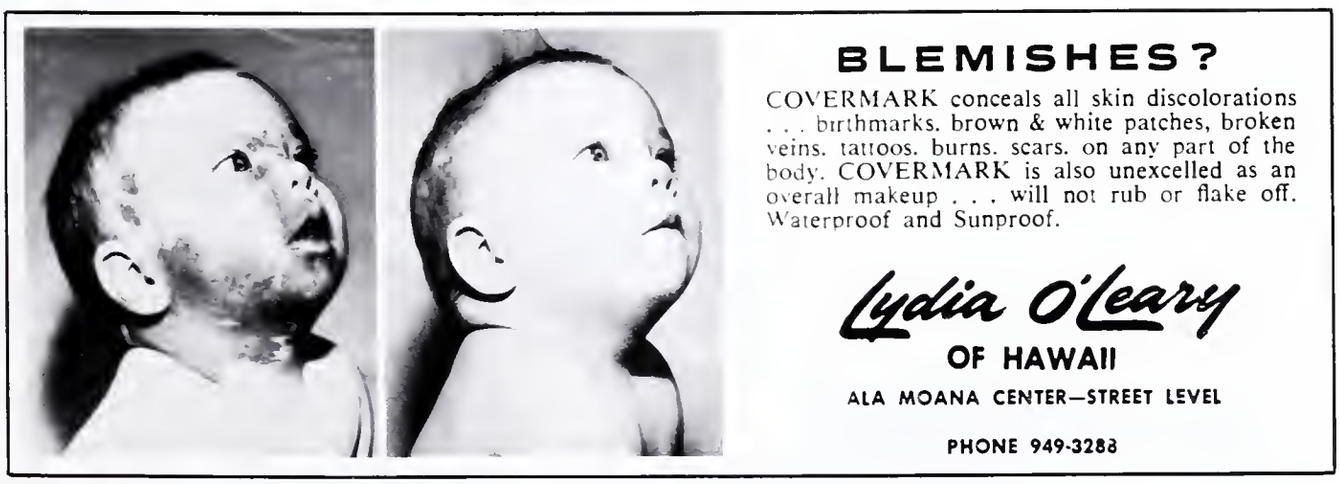
The minutes of the April 23, 1976 meeting were approved as circulated.

FINANCIAL REPORT

The March 1976 financial statement was accepted subject to audit.

REPORTS OF THE COMMITTEES AND COMMISSIONS

A. Ad Hoc Committee on Medical Malpractice: The Ad Hoc Committee on Medical Malpractice met to review the legislation enacted by the 1976 Hawaii State Legislature and prepare recommendations to the Council regarding future



PRESCRIPTION FOR THE FUTURE



KUKUI PLAZA

Buy office space instead of leasing.

Consider the effect of inflation on lease rents.

Assuming an inflation rate (Compound Annually)	4%	6%	8%
Percent increase in 10 years	48%	79%	121%
Percent increase in 20 years	119%	220%	387%
Percent increase in 30 years	324%	473%	976%

Scary isn't it? If you don't think it's true, look back 20 years! In addition to freezing costs over a long period of time, purchasing office space at Kukui Plaza offers other advantages:

☐ Tax Benefits (through depreciation deductions) ☐ Potential Appreciation ☐ The land lease at Kukui Plaza is set at $1.00 per month per unit FIXED UNTIL 2048!

OTHER ADVANTAGES OF KUKUI PLAZA:

- **Central Location.**
- **Abundant Public Parking.**
- **Large Resident Population Nearby.**

For more information, call John Langton

CHANEY

Aaron M. Chaney, Inc. ☐ Phone 521-6971

courses of action. The following recommendations were accepted as printed below:

(1) That the ad hoc committee on Medical Malpractice be continued and that they pursue amendments to the malpractice law in the 1977 State Legislature as recommended in Item (2).

(2) That the committee continue to pursue changes in the legal doctrines section of the malpractice law to include: statute of limitations change for minors, definition of the doctrine of res ipsa loquitur, collateral source rule, periodic payment of awards, and reduction of contingency fees.

(3) That the HMA submit a list of nominees for the Medical Conciliation Panels to the Board of Medical Examiners on an annual basis. The nominees will be elected by the county medical societies. That the HMA sponsor, together with the Hawaii Bar Association, a seminar for orientation on procedures and purposes of conciliation panels for the 25 physicians and 25 lawyers who are selected as panelists.

(4) That the HMA oppose the section of the law requiring insurance for licensure and that the HMA strongly consider filing a class action suit to test the constitutionality of such a law.

(5) That each county medical society arrange for an election process in their bylaws for nominations to the Board of Medical Examiners. These nominations should be submitted via the HMA.

(6) That the county societies define their highest Peer Review Committee if they have not already done so.

(7) That the next committee on Malpractice continue to work on a voluntary arbitration agreement that could be used by individual physicians.

The executive board was asked to look into the logistics of testing the insurance-for-licensure law, to consider a referendum of the membership on the subject, and to determine the financial feasibility of filing an injunction.

B. Convention Committee: Dr. Whelan, Convention Committee Chairman, reported that 10 guest lecturers from abroad have been invited to speak at the 1976 Annual Meeting. He noted that the postgraduate course fees discussed at the last Council meeting were to be used to help defray expenses for the meeting in general.

ACTION:
It was voted to approve course fees as follows: $10 per session for HMA Members; $15 per session for non-HMA members.

C. Commission on Health Service and Care: Dr. Bell reported that criteria for Intermediate Care Facilities had been reviewed by the Community Health Committee and was submitted to DSSH on May 5.

As president of Honolulu County Medical Society, Dr. Bell asked whether there were any objections from those present to submitting the names of the Council to serve on the Medical Conciliation Panels as representatives from Oahu. There were no objections.

D. Commission on Public Health: Dr. Kuboyama reported that articles and positions from the American Academy of Pediatrics and the AMA in regard to Swine Flu Vaccine were circulated. Dr. Ronald Hattis was present to discuss his report and resolution on the subject of Swine Flu and withdrew his resolution in favor of the resolution submitted by Dr. George Mills. The resolution was discussed at length and amended as follows:

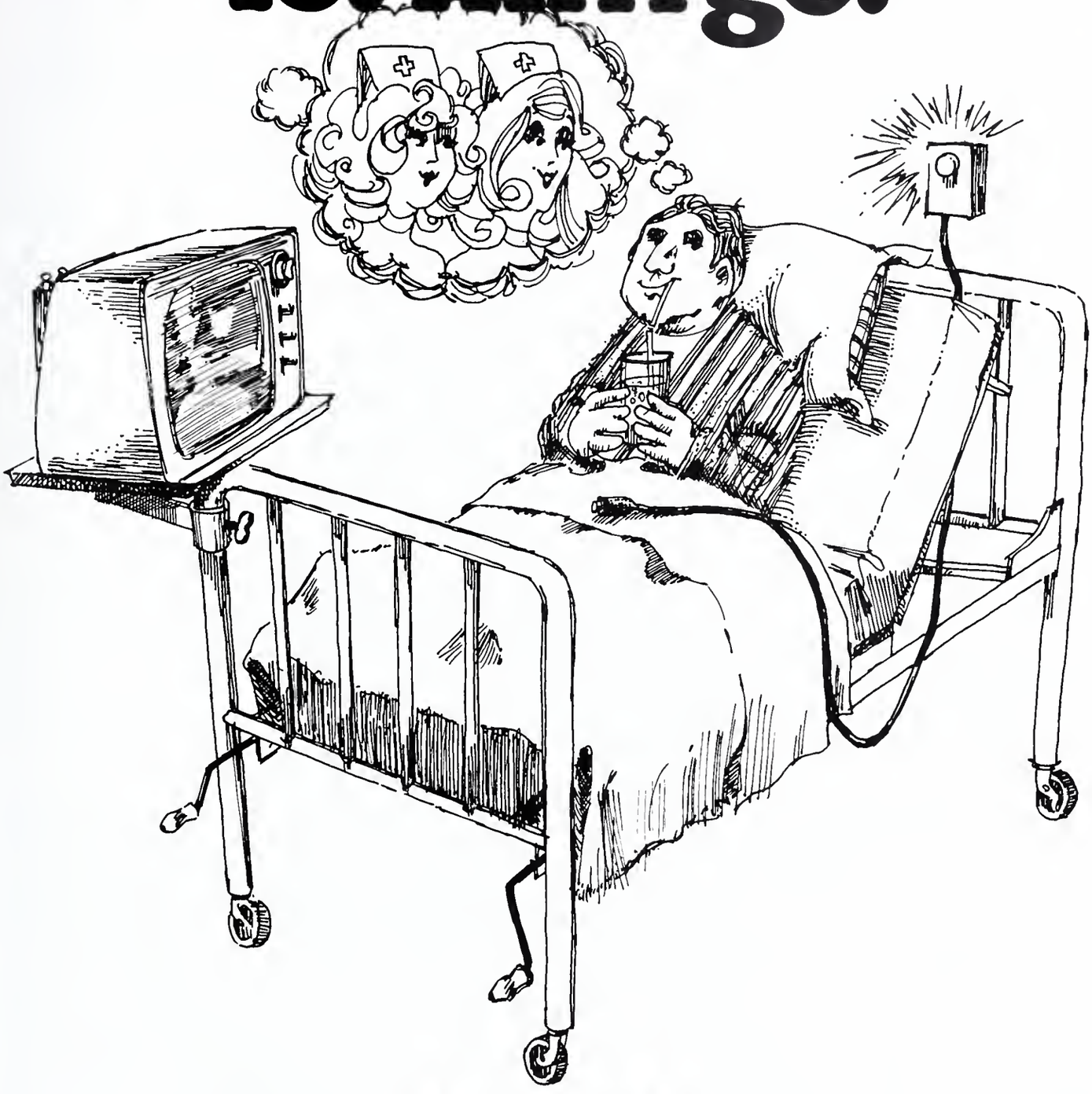
ACTION:
Resolved, **that the Hawaii Medical Association (with regard to Swine Flu)**

(a) Support the concept of early planning by the Department of Health;

(b) Designate the Executive Committee of the HMA as the liaison committee to work with the Department of Health of the State of Hawaii;

(c) Request that any promotional materials and publicity released by the Department of Health be reviewed for approval by HMA if participation is anticipated by Hawaii physicians;

Before he hollers, let him go.



Spare him the discomfort of an extra bundle of hospital bills.

When it's time to discharge a patient, remind him that HMSA can still cover therapy and diagnostic work on an out-patient basis.

It's less expensive, and another way doctors and HMSA can help the people of Hawaii hold down the cost of their medical care.

HMSA®

Hawaii Medical Service Association

(d) **Support the development of legislation which would "hold harmless" the physician in the area of immunization accidents especially when mass immunization is recommended by public health officials for the public good;**

(e) **Continue to evaluate the need, effectiveness and safety of mass immunization with swine flu vaccine; and be it further resolved**

That copies of the resolution be sent to the Director of Health and Governor of Hawaii and that they be advised that the HMA wishes to be consulted fully before any final decision to proceed with the immunization program is made; and be it further resolved

That copies of this resolution be sent to Hawaii's Congressional delegation and to the entire membership of the HMA.

E. PL93-641: A summary of the implementation of PL 93-641 in Hawaii was circulated for Council perusal.

F. Ad Hoc Committee on Building Management: At the last Council meeting, the ad hoc committee on building management was asked for a written description of the committee's function and guidelines.

ACTION:

It was voted to accept the definition and guidelines for the Ad Hoc Committee on Building Management with the amendment to the definition to read: "The Building Management Committee shall be appointed annually by the President of the HMA and confirmed by the Council. The committee shall consist of seven members with at least one member from each county medical society. The treasurer of the HMA shall serve as an ex-officio member of the committee. The committee shall report directly to the Council of the HMA according to the guidelines set forth."

The HMA move to 320 Ward Avenue is scheduled for August 23, 1976. The cost estimates for communication equipment, office modifications, furniture, and moving were presented in detail. Sources of financing are being investigated. All costs relating to moving, equipment, office modifications, etc. will be allocated to the Capital Investment Fund. There was discussion regarding the relocation of the Hawaii Tumor Registry to the new building. Cost estimates for moving and renovation for the HTR were included in the budget presented.

ACTION:

It was voted to approve the proposed budget of $50,000 and to authorize the Executive Committee to make the final decisions relative to the budget.

G. Peer Review: Mr. Won reported that HMA's attorneys are preparing peer review documents for the county medical societies and the HMA which might be followed in the review of cases referred by insurance carriers. The attorneys are also reviewing the HMA Bylaws with a view toward enabling the HMA's Peer Review Committee to be investigatory as well as an appellate committee. These documents will be circulated upon completion to all county societies.

H. Physician-Owned Insurance Companies: Dr. Mills reported that he attended an AMA sponsored Conference on Physician Owned Insurance Companies on May 21, 1976. A full report of the conference is on file. It was Dr. Mill's recommendation that the HMA take no action at this time on forming their own insurance company.

I. Marsh McClellan Proposal: A proposal to manage an insurance company for the HMA has been submitted by Marsh-McClellan Company. The Executive Committee will review the proposal in detail.

J. PAC PSRO: Mr. Won reported that HEW has approved PacPSRO as a conditional PSRO effective July 1, 1976.

K. Search Committee: Dr. Dang announced that Mr. Tom Thorson, HMA Executive Director, has announced his plans to retire at the end of 1976. Dr. Dang has appointed a Search Committee composed of HMA officers and the presidents of all county medical societies to seek a replacement for Mr. Thorson.

CORRESPONDENCE RECEIVED

A. Request for travel funds: A request from the American Medical Student Association of the University of Hawaii for travel to the AMSA meeting on May 28 was reviewed. The Council asked that a response be drafted requesting the students to plan for fund requests early in the year so they may be included in the HMA budget.

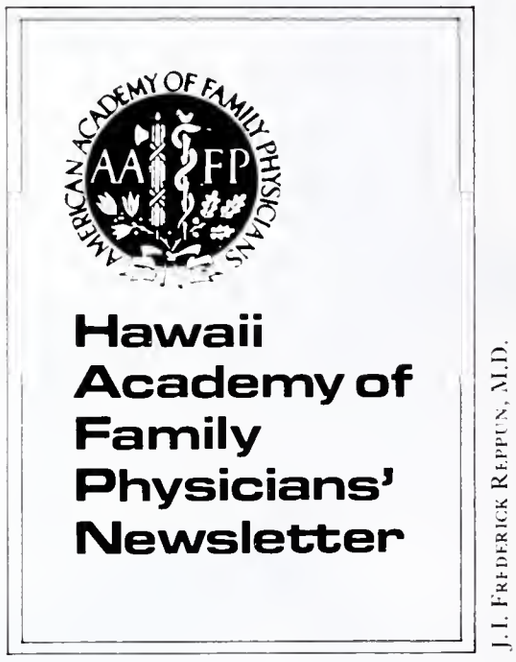
B. Request for participation in the American Association of Medical Assistants: The request for contributions to the Medical Assistants was reviewed. There are no funds budgeted for this purpose.

C. Request from the AMA: A letter from the AMA requesting state association cooperation in funding the travel expenses of student representatives to the AMA meeting was reviewed. There are no funds budgeted for this purpose.

ADJOURNMENT

The meeting adjourned at 11:45 p.m.

R. VARIAN SLOAN, M.D.
Secretary



News of Members—July Fourth has come and gone this Bicentennial year. **H.Q. Pang** was pictured practicing bell ringing at St. Peters Episcopal Church in the *Star-Bulletin* of 3 July. We were sitting on the sidewalk on Kapiolani Blvd. on the Fourth when the United Chinese Society's 15-man dragon serpentined its way down the boulevard going Diamond Head. What a surprise: "Pake" **Pat Walsh,** looking quite un-oriental was prancing as spiritedly as the youngest of the many "legs". Pat looked just as surprised when we hollered to him. **Norman Arai MD** of the UHSM '76 is starting his first year in the Family Practice Residency Program at Riverside Hospital in California. **Gerald Yorioka** writes well and likes to write; twice more in the *Star-Bulletin* Letters-to-the-editor, on 17 June deploring the way DSSH "saves" money by not paying what it really owes to hospitals in particular, thus forcing the hospitals to add to their rates to private patients—the taxpayer/patient thus paying twice to support DSSH and its "clients"; then again on 10 July, extolling the basic principles of freedom this bicentennial year.

Necrology—We're sorry to learn of the demise of **Toru 'Blue' Nishigaya's** wife Shizuko on 30 June. Our condolences to Blue.

C.M.E.—There is a wealth of good Continuing Medical Education Courses available and no HAFP member can argue that he has not the opportunity to fulfill his quota. The **Georgia AFP** is sponsoring another 1977 Course 100 by mail; members will receive the news release on this course, which those who are taking it say is "the best" and difficult and requires intense effort and lots of time on your part. Connec-

We're the only lab in the islands affiliated with Bio-Science.

Bio-Science Laboratories has an international reputation for quality and dependability, and we at Pathology Associates have gained much from our association with them.

Like Bio-Science, we offer a wide range of tests and expert personnel to perform them for you, using the most modern, automated equipment and technology.

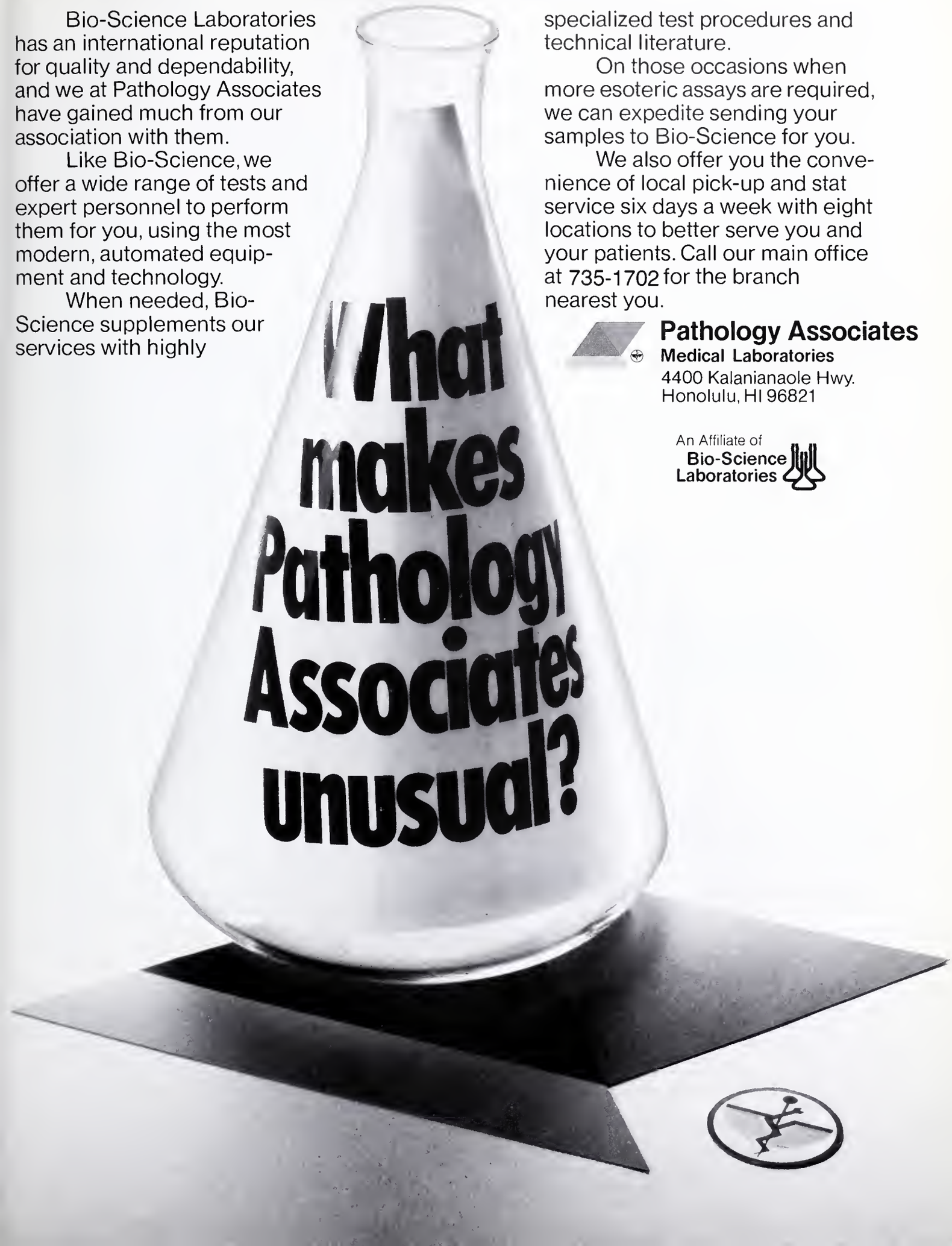
When needed, Bio-Science supplements our services with highly specialized test procedures and technical literature.

On those occasions when more esoteric assays are required, we can expedite sending your samples to Bio-Science for you.

We also offer you the convenience of local pick-up and stat service six days a week with eight locations to better serve you and your patients. Call our main office at 735-1702 for the branch nearest you.

Pathology Associates
Medical Laboratories
4400 Kalanianaole Hwy.
Honolulu, HI 96821

An Affiliate of
Bio-Science Laboratories

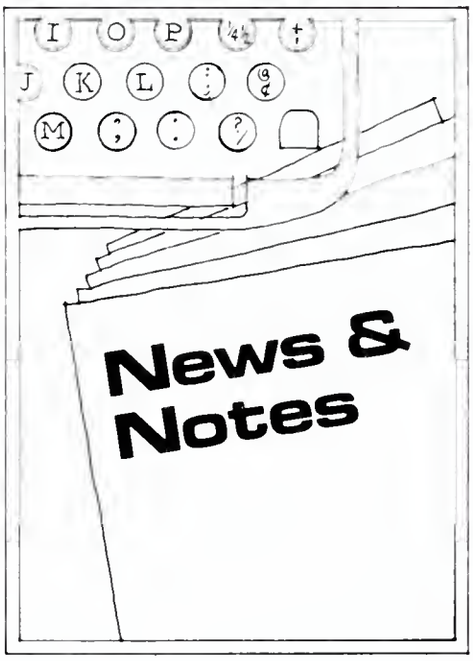


ticut and Ohio **Core Content** starts on 1 October and continues for 6 months. There is to be the **USC/Cardiology—**1976 at the Mauna Kea Beach Hotel 25 Sept.-2 October.

HAFP Council—meeting dates have again been changed to the third Thursday of each month at Kauikeolani Children's Hospital for lunch.

Boston—who's going to? The Congress of Delegates meets on 18 September. The 28th Annual Scientific Session starts on the 20th. By now, all HAFP members will have received **Felix Lafferty's** announcement of his intention to campaign for Director of A.A.F.P. He needs our all-out support; the competition is always fierce. Our Executive Secretary would like to hear from those of you who plan to attend the Boston meeting; please give her a call at 239-8383.

Medical Liability Law—all physicians must show financial responsibility to the extent of $100,000, or give evidence of having purchased an insurance policy 100,000/300,000 by 1 September. Otherwise, their license to practice medicine will be revoked. Base rate Class 11 General Practice (minor surgery in the office) is $1,702. Argonaut says they must raise the rate by 84% = $3,132. The Patients Compensation Fund is said to require another 30% to build a kitty of $5 million. Total = $4,072 premium per annum. Argonaut is the only carrier available to us; they will sell a 90-day policy and may raise the premium anytime they wish! How many of you will quit medicine? How many will have the nerve to practice without a license?



HENRY N. YOKOYAMA, M.D.

Professional Moves

Now comes the long awaited storm after the lull in this the Year of Our 200th Anniversary . . . It started with a drizzle in June as internist **Leoncio T. DeJoya** relocated to the Beretania Medical Dental Plaza and newly commissioned internist **Bryon Young** opened at Suite 304, 1507 So. King St. Then the deluge hit in July with eye man **James Brinkley Jr.** and allergist **Stuart Rusnak** joining The Honolulu Medical Group. **Alvin Fuse** rejoined the Pearl City Medical Associates (**Joe Nishimoto's** group) after completing his internal medicine training. Bone man **James Oda** opened at the Beretania Medical Dental Plaza and another bone man **Richard Kimura** opened his new office at 1833 No. King St. Yet another Pang was added to the Pang Eye, Ear, Nose, and Throat Clinic at 1374 Nuuanu Ave. with ENT man **Meredith Pang** joining up.

On the Big Island, urologist **Gordon Matsuda** joined the Hilo Medical Group and the Park-Hur Medical Clinic relocated to 133 Kinoole St., Hilo.

We note that on the City & County front, surgeon **Sam Yee** has accepted the rather tenuous position of acting C&C Physician which **Tommy Chang** assumed after **Paul Gebauer** resigned last December. Sam rather pessimistically opined, "Well, I'm going to give it a good try . . . The biggest problem is trying to be on top of everything at once . . ."

Miscellany

It was late and the Catholic Father was about to close the canteen when he noticed an attractive teenager left. Father: "Young lady, I have to close up." Girl: "Everyone left and I don't have a ride home." "Very well, I'll drive you home." While being driven home, the girl who had been sitting quietly suddenly grabbed the Father's arm and yelled excitedly, "Father! Father! You're passionate! . . . You're passionate!" The flabbergasted Father pushed her back and admonished sternly, "Young lady! You stay on your side and tell me where your home is!" "That's what I'm telling you. You're passing it!" (As told by **Charley Cachero,** our favorite humorist, in his immaculate Filipino accent.)

Life in These Parts

The Hawaii Medical Association spent $7,500 for the services of attorney **Kazuhisa Abe,** former Hawaii Supreme Court Justice, and was the big spender of all the groups listed . . . Under the new Lobbyist Registration Law, every lobbyist who spends more than $100 in any three months or who is paid for lobbying has to file expense and contribution statements . . .

Walter Gerwig, Kuakini peer review director, stopped us in the corridor: "You've heard the story of the golfers who complained about Joe in their foursome who had a heart attack on the 13th Hole and how they had to drag him along as they completed playing the remaining 5 holes . . . Well, I was reviewing charts at an outer island hospital and read the history on a patient who was doing well after he had a heart attack during a deep sea fishing trip with his friends. They made him as comfortable as possible while they fished another 7½ hours before coming in . . ."

W.A. Shrader, Jr. writes from Honokaa, Hawaii, expressing his political prefernces: "With the upcoming U.S. Presidential election in November, an issue of absolute urgency will confront us all as physicians: NHI. Mr. Jimmy Carter has stated that 'I'm not going to wait on welfare reform, national health insurance, etc. I intend to be ready to go with that the first of the year.' Mr. Reagan, on the other hand, is adamantly against NHI. Mr. Ford seems to be largely soft-spoken on the issue . . . The point of this letter is simple: A vote for Jimmy Carter is a vote for socialized medicine. Don't let Carter get a chance to perpetuate on this country the ruse of tricking the people into believing free health care is really free . . . I'd appreciate it if you could find a nook in your magazine to print this letter—here in Honokaa I seem to be fresh out of soap boxes!"

Studies in the past have demonstrated that fireworks on New Year's Eve in Honolulu caused significant respiratory problems . . . Now comes a study by **Carl Lehman** of Straub which shows that fireworks smoke is an irritant, rather than an allergen . . . Carl skin tested two groups, one with an extract of firecracker smoke and another with "normal air extract" . . . and found no difference in response . . . But an asthma sufferer responded, "I don't care what you call it—allergen or irritant, the effect is the same: Nasty . . ."

The first alcoholism treatment facility in the State opened in a wing of the new Hilo Care Center, a $4.3 million convalescent home in Hilo. The Post Hospital Recovery Unit is privately-owned and the executive director is **Howard Scanman,** former exec director of the 110 bed Alaska Alcoholic Treatment Center in Anchorage . . .

Kona physician **Edward Eisenberg** and Kona Medical Associates are being sued for $362,000 by a Kona man who waited 2 days to have a nail puncture wound of his hand treated . . . who then went to another physician a month later when he had difficulty opening his mouth and suffered muscle cramps. The latter physician treated him for a "tetanus infection" and apparently cured him after only four days of

STANFORD UNIVERSITY SCHOOL OF MEDICINE
OFFICE OF POSTGRADUATE MEDICAL EDUCATION

announces two interdepartmental five-day, comprehensive refresher courses

AT STANFORD UNIVERSITY

PRIMARY CARE

OCTOBER 11-15, 1976

FOR FAMILY AND GENERAL PRACTITIONERS, GENERAL INTERNISTS AND GENERAL PEDIATRICIANS

Designed as a review of the principles and procedures involved in the management of patients with problems commonly encountered in primary care, the program includes a morning lecture series and afternoon elective problem-solving sessions, seminars, and demonstrations. Tuition for the course is $250 with registration required no later than October 8.

General lectures will cover the following topics: scintigraphy, body scanning-computerized axial tomography, ultrasound, prevention of heart attack, management of hypertension, management of angina pectoris, pre-CCU management of heart attack, office management of arrhythmias, management of osteoarthritis and rheumatoid arthritis, headache, depression, transient ischemic attacks, management of common cutaneous complaints, management of urinary tract infections.

Elective sessions will include: **family dynamics:** crisis points in family life, problems in school, problems in middle life, problems surrounding death; **problems related to athletic activity:** the upper extremity, the lower extremity, the spine, reconditioning in middle life; **acid-base problems:** general principles, acidosis, alkalosis, mixed problems; **problem-oriented records:** general principles, the defined data base, construction of the problem list, workshop; **water and electrolyte problems:** water, sodium, potassium, miscellaneous problems; **immunology:** cellular basis of immunity, the immunoglobulins, antigen-antibody complex disease, allergy.

Faculty for this course will consist of twenty-five physicians of the Stanford University School of Medicine.

INTENSIVE CARE

NOVEMBER 1-5, 1976

FOR ALL PHYSICIANS INVOLVED IN THE CARE OF THE CRITICALLY ILL OR INJURED PATIENT

This course will review in detail the current status of management principles and procedures applicable to critically ill and critically injured persons. Topics of general interest will be covered in morning lectures, with the afternoon program offering a choice of problem-solving sessions and seminars and demonstrations in specialized topics. Twenty-nine Stanford University School of Medicine faculty members will participate.

General lectures will cover: hemodynamic monitoring; antiarrhythmic drugs; surgery for ischemic heart disease; respiratory failure: pathophysiology, manifestations and management, the principles and practical use of ventilators; hemostatic mechanisms; common bleeding problems: congenital-acquired; diabetic ketoacidosis and hyperosmolar coma; lactic acidosis; coma; thromboembolism; adult respiratory distress syndrome.

Elective sessions will include: **EKG problems:** acute myocardial infarction, tachyarrhythmias, bradyarrhythmias, ST-T changes in severe illness; **blood gas and acid-base problems:** respiratory acidosis and alkalosis, metabolic acidosis, metabolic alkalosis, oxygen transport; **water and electrolyte problems:** water, sodium, potassium, miscellaneous problems; **acute myocardial infarction:** cardiogenic shock, arrhythmias, emergency surgery, acute rehabilitation in CCU; **ICU methods:** resuscitation, monitoring: CVP and arterial lines, intracardiac and pulmonary lines, pacemakers; **trauma:** injuries to the face, the hands, the chest, the head and spine; **neonatal crises:** neonatal asphyxia, respiratory distress syndrome, sepsis, metabolic crises in the newborn; **ICU management problems:** use of blood components, acute renal failure, antibiotics in septic crises, hyperalimentation.

Tuition for this course is $250 with registration required no later than October 29. Early registration is advisable as this course has been oversubscribed in previous years.

FOR COMPLETE DETAILS SEND COUPON

Clip and mail to: OFFICE OF POSTGRADUATE MEDICAL EDUCATION
Stanford University School of Medicine, Room TA145, Stanford, California 94305
Telephone (415) 497-5594

PRIMARY CARE **October 11-15, 1976**
Please enroll me ($250 check enclosed) _____ Please send brochure _____

INTENSIVE CARE **November 1-5, 1976**
Please enroll me ($250 check enclosed) _____ Please send brochure _____

NAME _____ Specialty _____
Last First (please print)

ADDRESS _____ ZIP _____

(Checks payable to STANFORD UNIVERSITY SCHOOL OF MEDICINE)

hospitalization . . . (This is an age of miracles, it seems . . . It behooves us to give a tetanus shot for any puncture wound as malpractice prophylaxis . . .)

Al Kam, Aetna Life and Casualty Insurance representative who is well versed on Medicare payments to physicians, explains that the federal government lifted its freeze on physician fees in April 1974 and since, physician fees have increased substantially. Medicare either pays 80% of the doctors' reasonable charges or the doctors' prevailing charges from 1971, whichever is lowest . . .

Walter Watt has a grateful neighbor who wrote in a letter to the editor how his wife was choking to death at about 2:15 am. He yelled for Walter after dialing 911 for an ambulance . . . "He (Walter) followed me back in pajamas and at the same time a C&C ambulance arrived with two paramedics . . . It was these three trained men plus their equipment that brought my wife back to life from a heart attack."

Personalities

Pathologist **Grant Stemmerman** and moderator **Ron Pion** were discussing the relation of CA and diet on "In Conversation," an HMA Oceanic Cablevision project . . . Ron punned, "Yes, Dr. Reuben says in his book, first sex and then diet . . ." Stemmy reported, "As a matter of fact, teetotalers have 4 times more heart attacks than non-teetotalers . . . This is my only encouragement of sin . . . A modest encouragement . . ." Later when Stemmy mentioned that the average life expectancy of Japanese men in Hawaii is 77 and that the figure was high because of the longevity of the Issei, Ron prodded: "What is the wellness factor?" Stemmy: "I don't advocate a person should torture himself by jogging, etc. . . . I advocate a modest investment in physical exercise and a modest investment in good judgment."

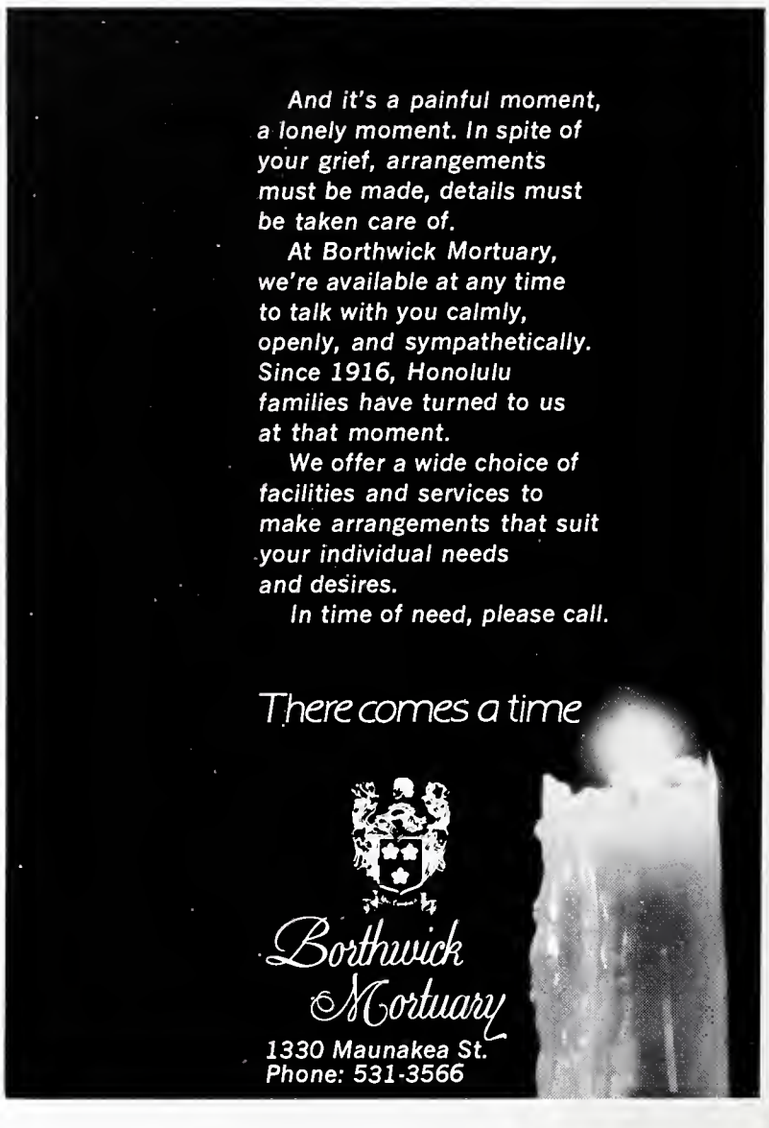
Henry Kempe, visiting professor of pediatrics, showed up at a Monday noon KCH lecture looking rather puffy around the gills . . . He had gone on a botanical excursion with nature loving **Charley Judd** and explained, "We encountered 125 varieties of plants and I was allergic to them all . . . I would recommend taking IV cortisone along . . ."

Two medical missionaries were given their due praise and recognition recently. **Bob Kraus** accompanied **Charley Judd** to Western Samoa where Charley's legend grew during a 3 year stay a decade ago. Wrote Bob: "The 10 year old legend of a Honolulu doctor whose name has become a household word here was dusted off last month as only Samoans can dust off a legend." Bob described how Charley's unannounced visit in June almost turned into a state occasion. The Prime Minister personally offered Charley the hospitality of the government, the sister of the King invited Charley to a formal tea in her open air fale, and the Western Samoa Medical Association threw a party so up and coming doctors might get a chance to meet the legend. When Bob asked a young doctor what was so special about this Judd, the young Samoan said with deep sincerity: "He is a great man . . . He is quiet and unassuming and he works very hard. He really knows his business and he has given so much to the Samoans that everybody respects him . . . When he left Samoa, the Parliament and the Prime Minister asked him to stay . . ."

Pat Hunter interviewed the second medical missionary, **Norman Sloan** in his Arcadia apartment where he reminisced over his long career in darkest Africa, The Virgin Islands, Hawaii, New Guinea, Samoa, Japan, and the Cook Islands . . . Norman "admitted that having a sense of adventure as well as a full blown case of 'itchy feet' were additional spurs in his life." As a small boy in Philadelphia, he was influenced by his local Lutheran pastor who had been a medical missionary in Liberia. When Norman finished med school, he applied to go as a medical missionary to the Lutheran Hospital in Monrovia where he remained from 1928 to 1935. Then he went to the Virgin Islands to work with leprosy patients after studying several months at Carville, LA. He was at St. Croix where 100 lepers were housed next to a rum factory. While there, he met

Our "Angels"

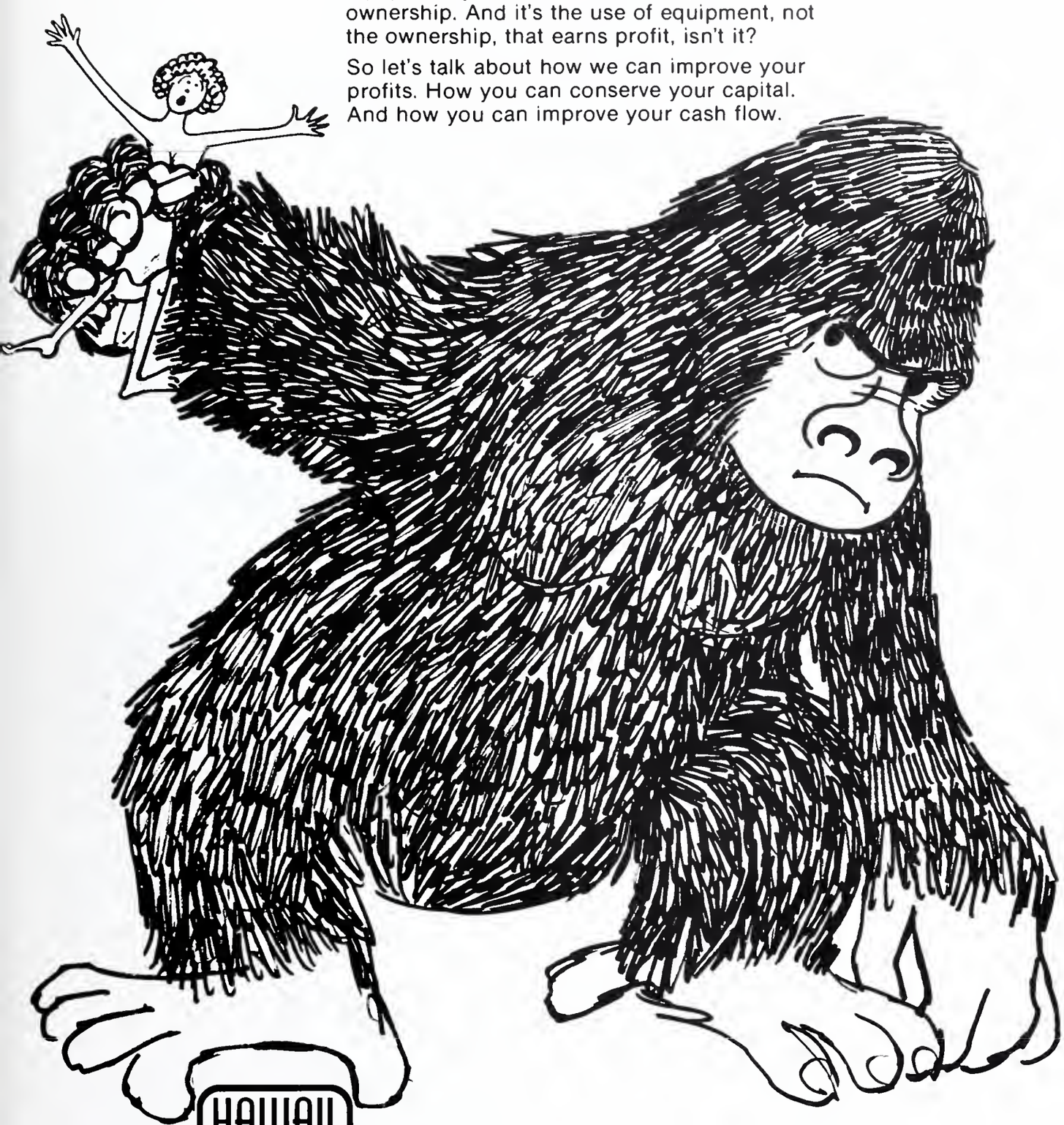
	Page
Borthwick Mortuary	244
Century Pacific, Inc.	
Jockey Club	223
Aaron M. Chaney, Inc.	
Kukui Plaza	238
First Hawaiian Bank	222
Hawaii Bancorporation, Inc.	
Bancorp Leasing	250
Hawaii Medical Leasing	245
Hawaii Medical Service Association	239
Hawaiian Trust Company, Ltd.	247
Herbert K. Horita Realty, Inc.	
Waialae Iki IV	232
Hilo Care Center	236
Eli Lilly and Company	
Darvocet/Darvon	226
Lydia O'Leary	
Covermark	237
Pathology Associates	241
Pharmaceutical Manufacturers	
Association	248,249
Roche Laboratories	
Valium	220,221
Roerig	
Atarax	224,225
Stanford University School	
of Medicine	243



Ownership
...today it's old-fashioned

Businessmen used to think equipment ownership was the only answer. Then they discovered today's answer—leasing. And Hawaii Leasing has the latest plans. Plans that give you the use of the equipment you need without the problems of ownership. And it's the use of equipment, not the ownership, that earns profit, isn't it?

So let's talk about how we can improve your profits. How you can conserve your capital. And how you can improve your cash flow.



Today's answer. HAWAII MEDICAL LEASING 700 Bishop St., Suite 902 • Honolulu, Hawaii 96813 • 546-2949

An activity of Amfac *Financial*

a young Honolulu internist **Clagett Beck** who later wrote him about a job opening in Kalaupapa which he took in 1940. There were 400 patients at Kalaupapa when he arrived and the biggest problem and cause of most deaths was tuberculosis. He stayed at Kalaupapa until 1950 when a political hassle caused him to resign. In 1951, he was back on the trail of leprosy with the South Pacific Commission. He started out in Dutch New Guinea, and then on to Canton. In 1955, he returned to Honolulu to work in the geriatrics branch of the State Health Dept. until he retired in 1966. During his trips to the Trust Territories for the South Pacific Commission, he heard of Pingelap in Ponape where he found 4% of the population with leprosy. In 1967, he and **Robert Worth** of the UH School of Public Health did a 3 year study on the effectiveness of DADDS (a long lasting form of DDS) injections every 77 days. The study proved that the drug was an effective preventive measure esp for young children . . .

Today, Norman collects books on leprosy and is researching material for a book on the first 2 years of Kalaupapa—before Father Damien arrived . . .

Sportsmen

Kyuro Okazaki, a spry 75, practices full time and carries a 22 handicap. Kyuro patterns his style after Chi Chi Rodrigues, his idol, and recently placed 3rd place in a field of 50 in the Annual Senior AJA Golf Tournament at Ala Wai GC . . .

Miscellany

Two physicians watched a patient shuffle gingerly along the hospital corridor, buttocks thrust back, torso bent forward, and face contorted with each painful step . . . Doctor A: "I'll bet you a dollar that he had a circumcision." Doctor B: "I'll take that bet. I'm sure he had a hemorrhoidectomy . . ." The patient when querried replied, "Sorry, you're both wrong. I was just trying to pass gas." (As told by our Public Health School friend **Richard Suehiro**)

Med school aphorism: The most important thing for a man between 20 and 30 is making love . . . from 30 to 40 is making money . . . and from 40 to 50 is making water. (**David Reuben** says from 50 on, making love should take the center stage again . . .)

"What do you call a Portuguese in a tree?" "A branch manager." (As told by **Becky Kendro,** HMA staff assistant)

Charley was in Waikiki over the July 4th weekend and the hookers were carrying signs saying, "Bicentennial Special . . . on one condition" Charley inquired as to what the one condition was and was told that they have to be "Minute men" (As told by our golfing friend, **Henry Yim**)

Kuakini CCU poster: "If you can't dazzle 'em with brilliance, baffle 'em with B.S." Another philosophical tidbit on their bulletin board: "Diseases enter by the mouth and misfortunes issue out of it."

Shig Horio Memorial Services . . .

The obituary requested that mourning attire be omitted so we wore our most comfortable Aloha attire as did everyone else . . . We knew Shig Horio would have wanted it that way . . . The Makiki Christian church was packed solid and we had to scrounge a folding chair in the foyer . . . We scribbled the following fragmentary notes on the program sheet . . . Arthur Johnstone of the Salvation Army gave the appreciation: "Shig was a secret salvationist . . . In this quiet man, we learned many lessons of life as well as of death . . . i.e., not only how to die, but how to live . . . I believe Shig in death is experiencing his greatest adventure of all . . . Shig never ministered physically only, but ministered spiritually as well . . . viz, he ministered the whole being, for God was part of his daily life . . . He was a modest man who knew the simple truth of the philosophy of life . . . He felt that what was easy for him should be easy for others . . . Shig was a robust athlete . . . We picture him with a surf board in one arm and a tennis racket in the other . . . He was the most tenacious, most aggressive competitor . . . I was constantly amazed at his vitality and at the zest for life in this gentle spirit . . . I admired Shig for his concern for Mae . . . He encouraged her growth so that she could be independent and on her own . . . Modesty precluded his accomplishments for he never talked about himself . . . Shig was a brilliant, yet uncomplex man . . . He grew into a gentle whole human being . . . not embittered by the trials and tribulations of the relocation . . . It's our hearts that give tribute—not our mouths . . . For whatever we say will fall short of the true stature of this man . . . We might be tempted to call this an untimely death, but rather I suggest we celebrate the timeliness of his life . . ."

Rev. Ted Ogoshi remarked: "On Wednesday morning, a neighbor saw Dr. Horio early in the morning jogging with his dog . . . Later that day, he played tennis and on his way home he had the accident, but there was *no* heart attack (referring to the shocking newspaper reports that Shig had suffered a heart attack before his accident) The family wants all of you to know that the cause of his death was *not* a heart attack . . . For Dr. Horio would want all you tennis players to keep playing tennis, all you surfers to keep surfing and all you joggers to keep jogging . . . The hardships Dr. Horio endured in growing up—life in an internment camp—he knew when he was touching life . . . He was on the board of the Blood Bank . . . He gave 95 pints in his life time . . . Dr. Horio was a man with convictions . . . He had deep feelings about the war and deep feelings about the hospital strike . . . As iron sharpens iron, so Dr. Horio sharpened us . . . He had a sense of honesty and integrity . . . He taught us many things . . . He taught us of life beyond death . . . of resurrection . . . He taught us that we are only a seed being planted . . . On tennis, he talked about that feeling when the mind, the eye, and the body came together . . . On surfing, he talked of the deep peace—a kind of religious experience . . . Shig frequently spoke from his pulpit and when he gave a prayer, he gave us a sense of standing before God . . . and Father, we thank you for accepting this man and for giving us 56 years of his life . . . He was blunt because he believed you were blunt . . . He was compassionate because he believed you were compassionate . . ."

Alex Roth was bleary eyed as he stood at the pulpit to pay tribute to his medical colleague and tennis partner. "I appreciate this opportunity . . . I knew Shig for 14 years . . . We both joined Kaiser Permanente . . . He had a rich background in medicine . . . He joined Kaiser because he honestly felt he could do more for more people . . . I played tennis with him that afternoon . . . I considered him to be *the* all around athlete—who while waiting for courts would be shooting baskets . . . He loved music . . . He was involved with the Blood Bank, the Salvation Army, and the Medical School. He was an amazing person and the most even tempered person who never used bad language . . . He never smoked or drank . . . He never had any disparaging remarks for anyone . . . He was a good friend . . . and I miss him very much . . ." (Alex's voice trailed) . . .

Rev. Ogoshi later announced that the monetary gifts will be used to establish a Dr. Shigeo Horio Memorial Scholarship fund at the UH Med School. "The family asks that you leave with joy and love in your hearts . . . Dr. Horio would have said, 'I have fought the good fight . . . I have finished the race . . . I have kept the faith . . .' "

Stemmy Says

When you make a diagnosis of esophageal carcinoma, you make two other diagnoses as well . . . ie, alcoholism and heavy smoking . . .

This business of carotid bruits . . . In the Japan-Hawaii heart Study, we made a careful surveillance of carotid bruits and found absolutely no correlation with subsequent strokes. They have no significance whatsoever . . . The sooner we forget about carotid bruits, the better . . .

60% of Japanese men with cirrhosis in this community have hepatomas . . .

You're worth a lot more than you think.



How much of that will the Government take?

Think about it. Your house. Your life insurance. The value of your pension or profit-sharing plan where you work. These assets add up to a lot, and every year, as your net worth increases, the need for planning increases. Because without sound planning, these assets can be seriously diminished through taxes.

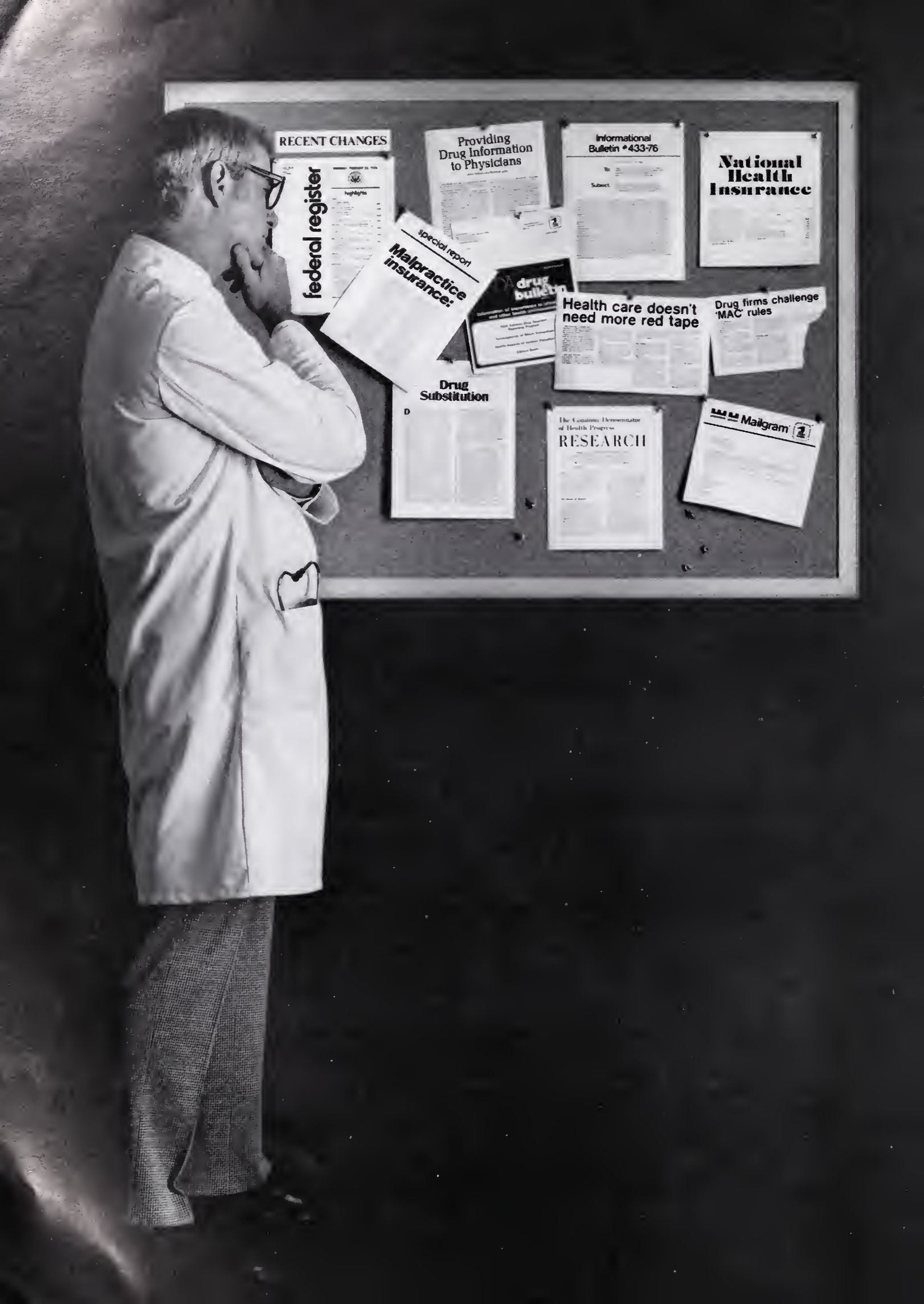
We save a lot of money for people like you. It's our business, and we're experts at it. Drop by and let one of our trust officers show you what Hawaiian Trust can do to increase your personal security.

You are worth more than you think. We don't think you should lose it.

Trust Hawaiian.

Hawaiian Trust Company, Ltd.

Financial Plaza of the Pacific • P.O. Box 3170 • Honolulu, Hi. 96802 • 525-8511
Wailuku Town House • Wailuku, Maui 96793 • 244-7965
120 Pauahi Street • Hilo, Hi. 96720 • 961-3784


RECENT CHANGES
federal register
Providing Drug Information to Physicians
Informational Bulletin • 433-76
National Health Insurance
special report
Malpractice insurance:
drug bulletin
Health care doesn't need more red tape
Drug firms challenge 'MAC' rules
Drug Substitution
RESEARCH
Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all nds of scrutiny. Your control over patient therapy is ing monitored, judged and occasionally abrogated, metimes by unknown third parties.

The worry is that in the wake of this focus, the rela- nship between you and your patient will be weakened, ithout offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, gulations or professional custom stipulate that your n-generic prescriptions be filled with the precise prod- ts you prescribe. But in the last five years, a dozen or ore State laws have been changed, permitting the phar- acist in most cases to select a product of the same eneric drug to fill any prescription.

Ironically, this dilution of physician control has ken place against a background of growing evidence at purportedly equivalent drug products may be in- quivalent, since neither present drug standards nor their nforcement are optimal. In fact, the FDA itself says it as not enforced the same standards for hundreds of follow-on" products that it had applied to the original DA approvals. Thus physician control over patient erapy is being eroded with a risk that patients may be xposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced rescription prices for consumers. Yet no documentation f any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is Federal regulation designed to cut the Government's rug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber ertifies on the prescription that a particular product is nedically necessary, the Government intends to pay only or the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

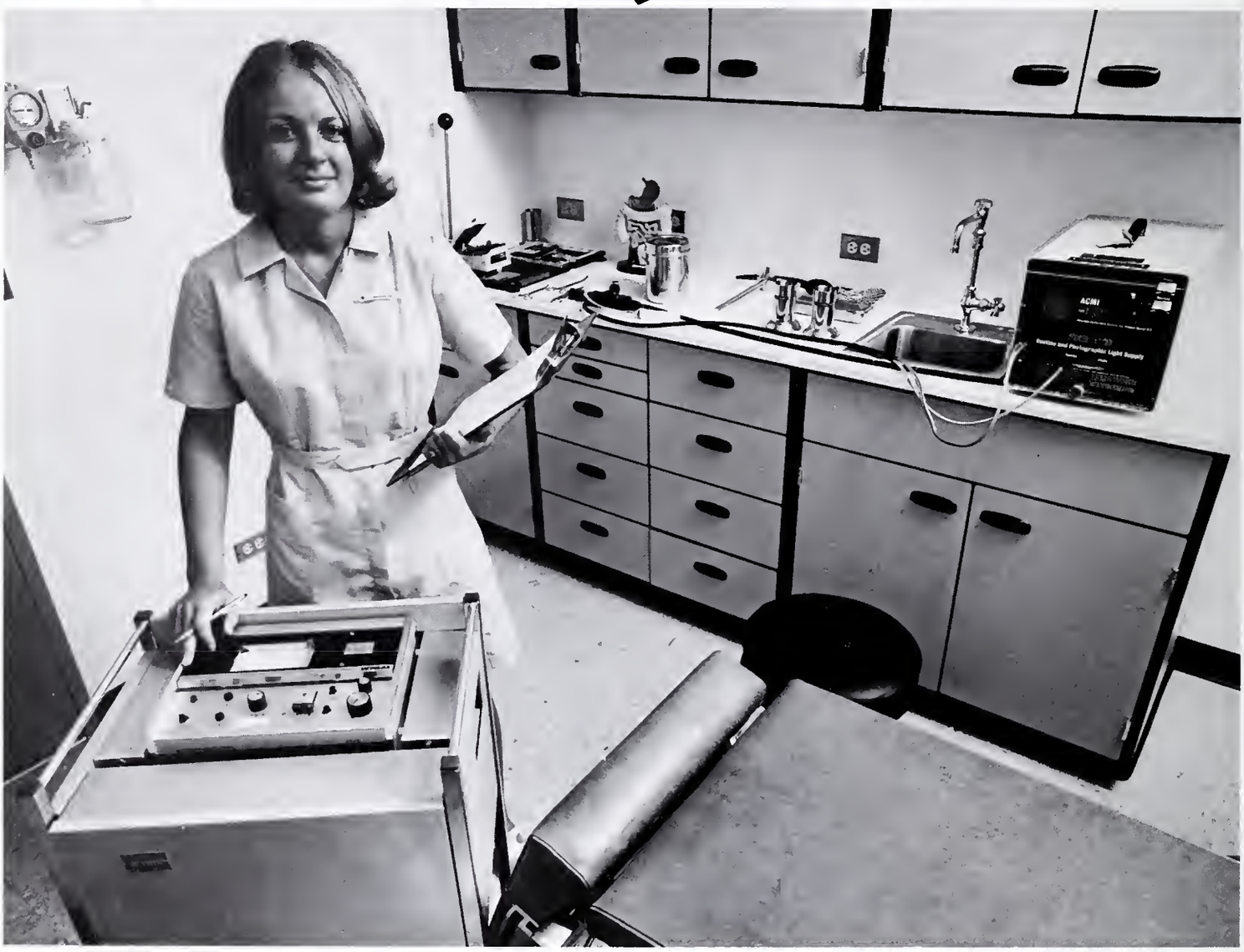
If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.

P·M·A

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

WHY LEASE MEDICAL EQUIPMENT?



It may be just what the doctor should order. Take a moment and look into it.

Why lease? Well, it has to do with money. Your money. We're Bancorp Leasing, and we're an affiliate of Bank of Hawaii. Together, we know a lot about how to make your money work for you. When you lease your medical equipment, you've got your hard-earned money available for other more pleasant or profitable investments. And there's no cash outlay either. Leasing is also a tax deductible expense. Leasing through us leaves you and your staff free of the paper work involved in equipment acquisitions. It's our worry.

Give us a call at 537-8810. If you like, we can make an appointment to come out and see you. There's no obligation. Except our obligation to help you get as much out of your capital as possible.

BANCORP LEASING

A subsidiary of Hawaii Bancorporation, Inc.
and an affiliate of Bank of Hawaii

Hawaii Bancorporation Leasing, Inc. / P. O. Box 2900, Honolulu, Hawaii 96846 / Phone 537-8810

SEPTEMBER, 1976
VOL. 35, NO. 9

Hawaii Medical Journal

CONTENTS

A New Record of Spirometra Mansoni, A Zoonotic Tapeworm, From Naturally Infected Cats and Dogs in Hawaii 261
O. Wilford Olsen, Ph.D. and Walter R. Haas, D.V.M.

High Speed Trephine Drill Lung Biopsy: A Pilot Study 263
W.A. Shrader, Jr., M.D., and C.J. Straehley, M.D.

Continuing Medical Education 269

Editorials 267

Hawaii Academy of Family Physicians' Newsletter 274

HMA Newsletter 266

In Memoriam 276

Letters to the Editor 255

New Members 276

The Library
Acquisitions Division SP
University of California, San Francisco
San Francisco California 94143

LIBRARY
U.C. SAN FRANCISCO
OCT 20 1976

Both often



Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium®
(diazepam) Ⓡ IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

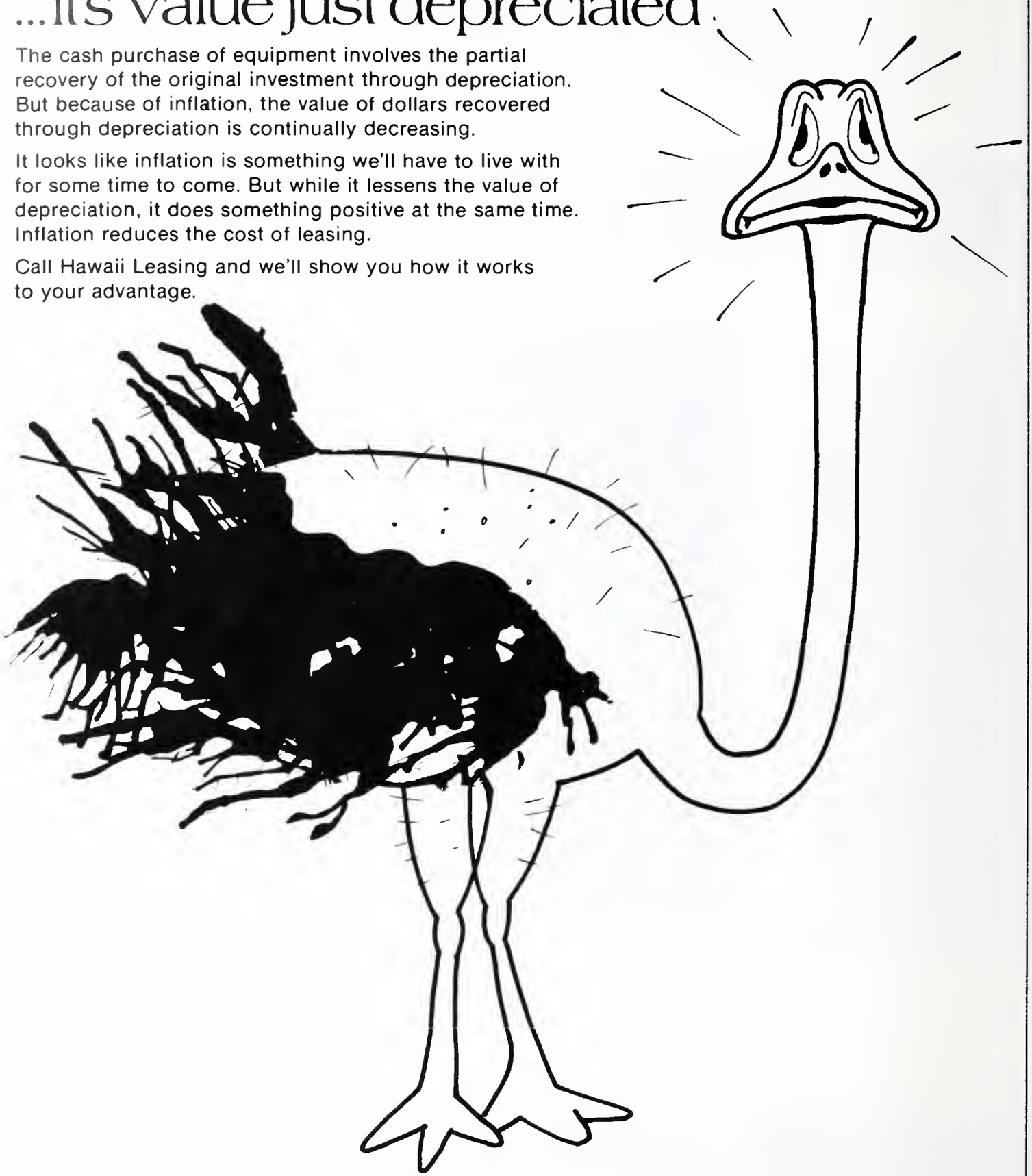
Depreciation

...it's value just depreciated.

The cash purchase of equipment involves the partial recovery of the original investment through depreciation. But because of inflation, the value of dollars recovered through depreciation is continually decreasing.

It looks like inflation is something we'll have to live with for some time to come. But while it lessens the value of depreciation, it does something positive at the same time. Inflation reduces the cost of leasing.

Call Hawaii Leasing and we'll show you how it works to your advantage.



Today's answer. HAWAII MEDICAL LEASING 700 Bishop St., Suite 902 • Honolulu, Hawaii 96813 • 546-2949

An activity of Amfac *Financial*

Hawaii Medical Journal

Published Monthly by the
HAWAII MEDICAL ASSOCIATION
(Incorporated in 1856 under the Monarchy)
320 Ward Avenue, Honolulu, Hawaii 96814

EDITORS

Editor, Harry L. Arnold, Jr., M.D.
News Editor, Henry N. Yokoyama, M.D.
Assistant Editor, Doris R. Jasinski, M.D., M.P.H.
Contributing Editor, Robert H. Moser, M.D.
Contributing Editor, J.I. Frederick Reppun, M.D.
Book Review Editor, Winfred Y. Lee, M.D.
Executive Editor, Paul Steward

OFFICERS

President, William W.L. Dang, M.D.
President-Elect, Calvin C.J. Sia, M.D.
Past President, Winfred Y. Lee, M.D.
Secretary, R. Varian Sloan, M.D.
Treasurer, Grover H. Batten, M.D.

County Presidents

Hawaii, Kenneth Hughes, M.D.
Honolulu, Douglas B. Bell, II, M.D.
Kauai Rieazi Remitio, M.D.
Maui, Clifford Moran, M.D.
Delegate to AMA, George H. Mills, M.D.
Alternate Delegate to AMA,
Herbert Y.H. Chinn, M.D.

Advertising Representatives
National:
HAWAII MEDICAL ASSOCIATION
320 WARD AVENUE
Honolulu, Hawaii 96814
Phone (808)536-7702
Honolulu:
LILITH JURRY, Phone 946-0053

The Journal may not be held responsible for opinions expressed in papers, discussions, communications, or advertisements. The advertising policy of the Hawaii Medical Journal is governed by the rules of the Council on Drugs of the American Medical Association. The right is reserved to reject material submitted for editorial or advertising columns. All material for publication must be in the hands of the editor on or before the 10th day of the month preceding publication date. Reprints of original articles will be supplied at actual cost. A reasonable number of illustrations accompanying an article will be accepted for printing. The right is reserved to ask the author to bear cost of these when it is found necessary to do so.

Copyright 1976 by the Hawaii Medical Association, Honolulu, Hawaii. 2nd class postage paid at Honolulu, Hawaii. Office of Publication: 320 Ward Avenue, Honolulu, Hawaii 96814.



To The Editor:

Re: Act 219, Medical Professional Liability

I have yet to meet the person who does not agree that Act 219 represents a travesty of judgment. As a legislative attempt to control costs of malpractice insurance premiums and costs of providing medical care it is a bizarre but eloquent example of the illogic method of thought so often the product of legislative response to problem solving. (Solve a problem by creating a new one.) It lacks common sense and is unethical.

Act 219 reinforces the concepts that have arisen in response to medical liability insurance practices and the court's role in dealing with the majority of such cases. It is the end stage of the ill-conceived notion that physician liability insurance is meant to compensate the victim of accident, ill fortune, unusual illness and honest human error in the course of receiving medical care, as well as those who have been subjected to true malfeasance and criminal activity or neglect. Good reason dictates that only the last of these should be the physician's liability. Act 219 requires that the physician pay for all of these.

In fact, the very concept of insurance would suggest that if any protection is to exist for other than criminal malfeasance the patient should be the provider of such insurance—not the physician.

Act 219 not only allows for increases in liability premiums, but provides for a fund to be paid into by physicians to supplement payments to individuals who do not do well in the hands of medical practitioners. Even if we disregard this potential miscarriage of liability the patient will again, in the end, shoulder the burden of these costs.

Many physicians have paid their Medical Society dues this year because without doing so they cannot purchase liability insurance. The Medical Society's suit as an attempt to rectify the injustice to the people of this state in Act 219 will be valueless. It will be too little too late.

continued page 274


BREATHABILITY...

In bronchospasm*associated with asthma,
chronic bronchitis, and emphysema

MARAX®

TABLETS: ephedrine sulfate, 25 mg; theophylline, 130 mg; Atarax® (hydroxyzine HCl), 10 mg
SYRUP, per 5 ml: ephedrine sulfate, 6.25 mg; theophylline, 32.50 mg; Atarax® (hydroxyzine HCl), 2.5 mg; and ethyl alcohol, 5% v/v

the only bronchodilating/bronchospasmolytic agent with Atarax® (hydroxyzine HCl) instead of barbiturates, which have the potential to depress respiration



*This drug has been evaluated as possibly effective for this indication. See Brief Summary on following page.



Marax®

TABLETS: ephedrine sulfate, 25 mg; theophylline, 130 mg; and Atarax® (hydroxyzine HCl), 10 mg

SYRUP, per 5 ml: ephedrine sulfate, 6.25 mg; theophylline, 32.50 mg; Atarax® (hydroxyzine HCl), 2.5 mg; and ethyl alcohol, 5% v/v

☐ Marax is the only bronchodilating/bronchospasmolytic agent* with Atarax® (hydroxyzine HCl) instead of barbiturates, which have the potential to depress respiration

☐ Marax contains Atarax to help prevent excessive excitation by modifying the central stimulatory action of ephedrine

***Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" Effective: For controlling bronchospastic disorders.
Final classification of the less than effective indication requires further investigation.

Contraindications: Because of the ephedrine, Marax is contraindicated in cardiovascular disease, hyperthyroidism, and hypertension. This drug is contraindicated in individuals who have shown hypersensitivity to the drug or its components. Hydroxyzine, when administered to the pregnant mouse, rat, and rabbit induced fetal abnormalities in the rat at doses substantially above the human therapeutic range. Clinical data in human beings are inadequate to establish safety in early pregnancy. Until such data are available, hydroxyzine is contraindicated in early pregnancy.

Precautions: Because of the ephedrine component this drug should be used with caution in elderly males or those with known prostatic hypertrophy.

The potentiating action of hydroxyzine, although mild, must be taken into consideration when the drug is used in conjunction with central nervous system depressants; and when other central nervous system depressants are administered concomitantly with hydroxyzine their dosage should be reduced.

Patients should be warned—because of the hydroxyzine component—of the possibility of drowsiness occurring and cautioned against driving a car or operating dangerous machinery while taking this drug.

Adverse Reactions: With large doses of ephedrine, excitation, tremulousness, insomnia, nervousness, palpitation, tachycardia, precordial pain, cardiac arrhythmias, vertigo, dryness of the nose and throat, headache, sweating, and warmth may occur. Because ephedrine is a sympathomimetic agent some patients may develop vesical sphincter spasm and resultant urinary hesitation, and occasionally acute urinary retention. This should be borne in mind when administering preparations containing ephedrine to elderly males or those with known prostatic hypertrophy. At the recommended dose for Marax, a side effect occasionally reported is palpitation, and this can be controlled with dosage adjustment, additional amounts of concurrently administered Atarax (hydroxyzine HCl), or discontinuation of the medication. When ephedrine is given three or more times daily patients may develop tolerance after several weeks of therapy.

Theophylline when given on an empty stomach frequently causes gastric irritation accompanied by upper abdominal discomfort, nausea, and vomiting. Administration of the medication after meals will serve to minimize this side effect. Theophylline may cause diuresis and cardiac stimulation. The amount of Atarax (hydroxyzine HCl) present in Marax has not resulted in disturbing side effects. When used alone specifically as a tranquilizer in the normal dosage range (25 to 50 mg three or four times a day), side effects are infrequent; even at these higher doses, no serious side effects have been reported and confirmed to date. Those which do occasionally occur when Atarax (hydroxyzine HCl) is used alone are drowsiness, xerostomia and, at extremely high doses, involuntary motor activity, unsteadiness of gait, neuromuscular weakness, all of which may be controlled by reduction of the dosage or discontinuation of the medication. With the relatively low dose of Atarax (hydroxyzine HCl) in Marax, these effects are not likely to occur. In addition, the ataractic action of Atarax (hydroxyzine HCl) may modify the cardiac stimulatory action of ephedrine, and concurrently, increasing the amount of Atarax (hydroxyzine HCl) may control or abolish this undesirable effect of ephedrine.

Marax syrup contains a tartrazine dye (FD&C Yellow No. 5), which has been shown to rarely produce a variety of hypersensitivity reactions, particularly in aspirin-sensitive individuals.

Dosage: The dosage of Marax should be adjusted according to the severity of complaints, and the patient's individual toleration.

Tablets: In general, an adult dose of 1 tablet, 2 to 4 times daily, should be sufficient. Some patients are controlled adequately with 1/2 to 1 tablet at bedtime. The time interval between doses should not be shorter than four hours. The dosage for children over 5 years of age and for adults who are sensitive to ephedrine, is one-half the usual adult dose. Clinical experience to date has been confined to ages above 5 years.

Syrup: The dose for children over 5 years of age is 1 teaspoon (5 ml), 3 to 4 times daily. Dosage for children 2 to 5 years of age is 1/2 to 1 teaspoon (2.5-5 ml), 3 to 4 times daily. Not recommended for children under 2 years of age.

How Supplied: Marax Tablets are available as light blue, scored tablets in bottles of 100 and 500.

Marax Syrup is available in pints and gallons, and should be dispensed in amber-colored bottles.

ROERIG Pfizer

A division of Pfizer Pharmaceuticals, New York, N.Y. 10017



THE DOCTOR'S OFFICE

After six frantic mothers, four runny noses, nine vague complaints and one embarrassing rash, you deserve furniture from Sen.

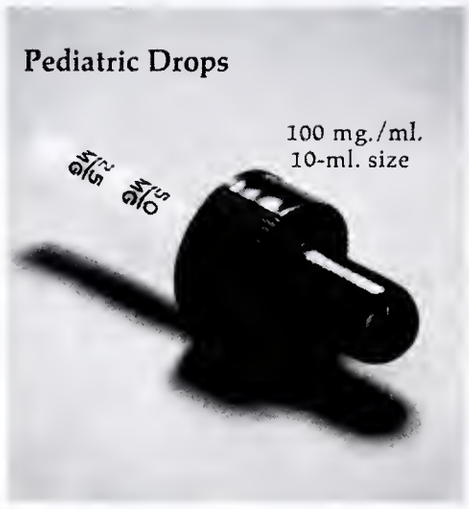
sen

SEN COMPANY/904-KOHOU/HONOLULU, HI 96817/848-0251

easy to take







Keflex®
cephalexin

Lilly

Additional information available to the profession on request.
Eli Lilly and Company
Indianapolis, Indiana 46206

500738

Beware those raw frogmeat poultices!

A New Record of *Spirometra mansoni*, A Zoonotic Tapeworm, From Naturally Infected Cats and Dogs in Hawaii

O. WILFORD OLSEN, Ph.D.*, *and* WALTER R. HAAS, D.V.M., *Lihue*

● *When Ash*[2] *published his account of a survey of the parasites of cats and dogs of Honolulu, and Alicata*[1] *issued his definitive monograph on the parasites of man and domestic animals of Hawaii, neither author mentioned tapeworms of the cosmopolitan genus Spirometra which contains species of medical and veterinary importance.*

For the past six years, one of us (W. R. H.) has been finding *Spirometra,* either as strobilae, eggs, or both, in cats and dogs entering his veterinary clinic at Lihue on the island of Kauai.

Of 84 animals examined—82 cats and two dogs—eight cats and both dogs were infected with diphyllobothriid cestodes, as evidenced by eggs in the fecal examinations, or by strobilae or fragments of them obtained at postmortem examination or that were voided spontaneously.

Specimens from two cats included an entire strobila, 125 cm long, passed by one cat while being examined on the table; lengths of mature and ripe proglottids were voided by another.

In addition to these specimens, two similar diphyllobothriid strobilae, one 198 cm and the other 68 cm long, were obtained from an euthanized cat. Unfortunately, both specimens were lost prior to critical examination.

Fecal examination of dogs averaged one diphyllobothriid egg per low power field as compared with up to 50 per field for cats.

Identification

Examination of the worms, using the criteria set forth by Mueller,[7] led to the conclusion that they are *Spirometra mansoni.* Differences in *S mansoni* and *S mansonoides* (Mueller[6]) are based on the morphology of the fully developed uterus and the course of the vagina. The uterus of *S mansoni* consists of a varying number of transverse loops, usually four, sometimes more. The walls of the posterior coils are thickened. In *S mansonoides*, on the other hand, the uterus consists of two series of simple coils, an anterior and a posterior one joined by a narrow duct. The wall of the posterior coil is thin. The pattern of conformation of the uterus is constant. In addition to the uterine characteristics, the vagina of *S mansoni* has marked lateral undulations, whereas that of *S mansonoides* is approximately straight.[7]

Biology and Ecology

The life cycle of *S mansoni* is complex, requiring two intermediate hosts and may include several collector, or paratenic, hosts.

Undeveloped eggs are passed in the feces of infected dogs and cats, the natural definitive hosts. In water, the eggs develop, each producing a six-hooked embryo clothed in a ciliated covering and is known as coracidium (Fig. 1, B-E).

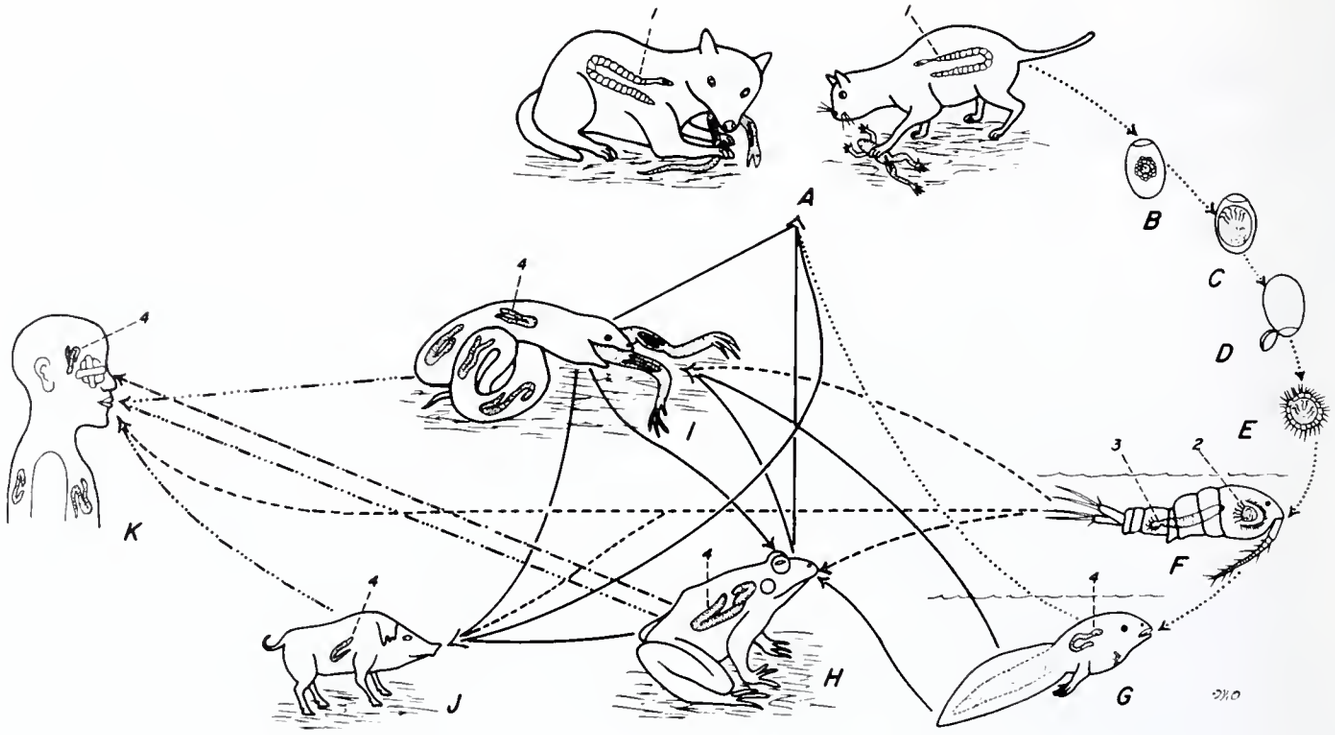
Upon hatching,the swimming coracidia attract cyclops which eat them (Fig. 1, F). In the gut of the cyclops, the ciliated envelop of the coracidium is shed and the six-hooked embryo, or hexacanth, burrows through the gut wall into the hemocoel. It develops into an elongated, unsegmented, worm-like procercoid which is infective to the next host in the cycle (Fig. 1, F).

When infected cyclops are eaten by tadpoles, the second intermediate host, the procercoids are liberated from the the cyclops by the action of the digestive juices. Procercoids, like the hexacanths, migrate through the intestinal wall

*Department of Zoology and Entomology,
Colorado State University,
Fort Collins, Colorado 80523

Accepted for publication November 18, 1975.

FIGURE 1.—*A. Dog and cat definitive hosts. B. Underdeveloped egg passed in feces of dogs and cats. C. Embryonated egg in water. D. Empty shell of hatched egg. E. Ciliated coracidium containing the six-hooked hexacanth. F. Cyclops first intermediate host. G. Tadpole second intermediate host. H-K. Paratenic, or collector, hosts. H. Frog. I. Snake. J. Feral pig. K. Man.*



1. Adult cestode in small intestine of definitive hosts.
2. Hexacanth being freed from ciliated covering in intestine.
3. Procercoid in hemocoel.
4. Plerocercoid or sparganum.

. Simplest type of life cycles consisting of definitive hosts (A), eggs (B-D), coradidium (E), cyclops first intermediate host containing hexacanth and procercoid (F); tadpole second intermediate host with plerocercoids (G) infective to definitive hosts (A).

———— Paratenic phase of the life cycle that occurs when animals, other than definitive hosts, harboring plerocercoids prey upon each other, thereby collecting plerocercoids (H, I, J).

– – – – – Paratenic phase of the life cycle that arises from hosts swallowing infected cyclops while drinking water or pursuing food in the water (F, H, I, K); the procercoids develop into plerocercoids.

—·—·— Zoonotic phase of the life cycle that occurs when plerocercoids transfer from raw frog meat used as poultices on the human body (H, K).

—···— Zoonotic phase of the life cycle that results when raw meat of frogs, snakes, feral pigs containing plerocercoids (H, I, J) is eaten by man (K).

into the celom. Continuing their migrations, they journey to the muscle fascia and subcutaneous tissues. In these locations, they transform into large, folded, worm-like larvae known as plerocercoids (Fig. 1, G). The term sparganum refers to all plerocercoids of the Diphyllobothriidae whose life cycles have not been completed and the adult stage is unknown.

The life cycle is completed in the most direct manner when plerocercoids in tadpoles or frogs metamorphosed from infected tadpoles are eaten by dogs and cats. In the definitive host, plerocercoids freed in the alimentary canal develop to adult worms in the small intestine. (Fig. 1, A).

Ecologically, the spargana are extremely resourceful in utilizing other animals as a means of transport to definitive hosts. Frogs and snakes that swallow infected cyclops while pursuing prey in the water become infected with spargana (Fig. 1, H, I). Indeed, any animal other than a definitive host, i.e., cat or dog, eating others harboring spargana acquires them in its own tissues[3] (Fig. 1, H-K). Mammals swallowing infected cyclops while drinking become infected with sparagana (Fig. 1, J, K). Animals such as these which acquire the spargana are designated as collector, or paratenic, hosts. Spargana from any of these sources are capable of development to adult cestodes when swallowed by cats and dogs (Fig. 1, A).

Spargana as Zoonotic Parasites

A zoonosis is an animal disease which is transmitted to man.[5-9] In this respect, *S mansoni* occurs as a sparganum in the tissues of man and represents a zoonotic condition.

Sparganosis as a zoonosis results in human beings when they 1) swallow procercoid-infected cyclops along with drinking water from ponds; 2) eat the raw or inadequately cooked flesh of plerocercoid-infected frogs, snakes, pigs, and other mammals; and, finally, 3) apply plero-

cercoid-infected raw flesh of frogs as poultices to wounds or inflamed eyes.[5]

Snake and frog meat is eaten raw (Fig. 1, K) by the people of Hong Kong[4] and of Korea.[10] Raw skinned frogs used as poultices on the skin or eyes (Fig. 1, K) provide a source of infection in Indochina when the spargana leave the meat and actually penetrate the eye to produce ocular sparganosis or the skin, resulting in subcutaneous infection.[5]

The extensive studies by Mueller[8] on *Spirometra mansonoides* from North America have provided much important information on the biology, ecology, and zoonoses of this medically important genus of cestodes.

REFERENCES

1. Alicata JE: Parasitic infections of man and animals in Hawaii. *Hawaii Agr Exp Sta, Tech Bull* 61, 138 pp. 1964.
2. Ash LR: Helminth parasites of dogs and cats in Hawaii. *J Parasit* 48:63-65, 1962.
3. Corkum KC: Sparganosis in some vertebrates of Louisiana and observations on human infection. *J Parasit* 52:444-448, 1966.
4. Huang CT, Kirk R: Human sparganosis in Hong Kong. *J Trop Med Hyg* 65:133-138, 1962.
5. Meyer MC: Cestode zoonoses of aquatic animals. *J Wildlife Dis* 6:259-254, 1970.
6. Mueller JF: A *Diphyllobothrium* from cats and dogs in the Syracuse region. *J Parasit* 21:114-121, 1935.
7. Comparative studies on certain species of *Diphyllobothrium*. *J Parasit* 22:471-478, 1936.
8. Host-Parasite relationships as related by the cestode *Spirometra mansonoides*. *In* Host-Parasite Relationships, J.E. McCauley, ed., Oreg. State Univ. Press, Corvallis, pp. 15-58, 1966.
9. Sprent JFA: Helminth "Zoonoses": an analysis. Helminth. Abst. 38:333-351, 1969.
10. Weinstein PP, Krawczyk JH, Peers JH: Sparganosis in Korea. *Am J Trop Med Hyg* 3:112-124, 1954.

For easier biopsy . . .

High Speed Trephine Drill Lung Biopsy: A Pilot Study

W. A. SHRADER, JR., M.D.*, *and* C. J. STRAEHLEY, M.D.**, *Honolulu*

The technique of percutaneous drill lung biopsy has been employed on a clinical basis for several years in the United States, after fairly extensive usage by Steel[2,3] in England since 1967. Other studies, including those of ZaVala[1] and Castillo, et al,[7] since that time, have shown it to be a safe and worthwhile diagnostic procedure, superior to other previously employed methods. The present study is the first of its kind done in Hawaii in order to determine the safety and value of high speed trephine drill biopsy

Materials and Methods

This study consisted of 20 patients, 12 men and 8 women, ranging from 33 to 81 years of age. The method of biopsy employed here is similar to that of ZaVala.[1] The biopsies were accomplished either in the x-ray department under fluoroscopic guidance for smaller solitary lesions, or in the operating suite for more diffuse lesions.

The equipment* consists of a small, lightweight, hand-held, pneumatic drill, powered in

* Chief Surgical Resident, The Queen's Medical Center, Honolulu, Hawaii

**Chief of Surgery, The Kaiser Foundation Hospital, Honolulu, Hawaii

Accepted for publication October 14, 1975.

Address reprint requests to Dr. C. J. Straehley, Hawaii Permanente Medical Group, Inc., 1697 Ala Moana Boulevard, Honolulu, Hawaii 96815.

*Manufactured by Down Brothers and Meyer Phelps, Ltd. Distributed by Down's Surgical, Inc., Niagara Falls, New York.

this study by liquid nitrogen, affording approximately 30,000 RPM, as opposed to the 15,000 RPM compressed air drill used in most previous studies. The hollow trephine is fitted to the drill using a Leur fitting and is 7.5 cm. long, with an external diameter of 3 mm. and an internal diameter of 2.1 mm. The trephine is rifled internally for maximal specimen retention and comes with pointed stylet to facilitate insertion through the chest wall.

The site of the biopsy depends upon the location of the lesion, and the patient is positioned accordingly, usually sitting, lateral decubitus or prone. Preoperative medications usually consist of a mild sedative. The patient is instructed not to move during the procedure.

The patient is prepped and draped as usual and the chest wall is infiltrated with a local anesthetic to the parietal pleura. A small stab wound is made at the desired point of entry. The trephine, which is sterile, with its stylet, is inserted into the parietal pleura, but not into the lung, and the stylet is removed. The drill (unsterile) is then handed to the operator and fitted into the trephine. The drill is then fully activated and advanced with one fairly rapid, smooth motion into the site to be biopsied. A sterile syringe containing citrate is then applied to the trephine, after the drill is disconnected, and suction is applied while the trephine is removed in one motion. The operator's thumb should cover the end of the trephine during the change-over. A small dressing is placed over the stab wound.

The specimen is discharged from the trephine into normal saline and sent to Pathology for fixation. If special stains are desired, these are requested.

Postoperatively, a PA chest film is obtained immediately, to look for pneumothorax. This is repeated usually the next morning. The patient's vital signs are monitored closely for several hours after the biopsy. Discharge may be on the first postoperative day after an x-ray has ruled out the presence of pneumothorax.

Results

The histologic results of 20 trephine drill lung biopsies are listed in Table 1.

TABLE 1—*Histology of 20 Drill Lung Biopsies*

1. Primary Bronchogenic Carcinoma	5	
a. Bronchiolo-alveolar Cell Carcinoma		1
b. Adenocarcinoma		1
c. Poorly Differentiated Carcinoma		3
2. Carcinoma, Site Unknown	1	
3. Carcinoma, Metastatic	2	
a. Adenocarcinoma (Breast)		1
b. Squamous (Tonsillar Pillars)		1
4. Fibrosing Interstitial Pneumonitis	2	
5. Fibrosis with Leimyomatous Hyperplasia (Possible Lymphangiomyomatosis)	1	
6. Fibrous Proliferation with Chronic Inflammation	1	
7. Pleural Fibrosis, Pulmonary Fibrosis	1	
8. Suppurative Bronchitis, Bronchiolitis, Acute and Chronic Bronchopneumonia	1	
9. Sarcoidosis	1	
10. Granulomatous inflammation, Compatible with TB	1	
11. Pneumocystis Carinii Pneumonia	1	
12. Normal Lung Tissue*	1	
13. Inadequate Tissue	2	
TOTAL	20	

*Biopsy was to rule out sarcoidosis.

Complications are summarized in Table 2. Pneumothorax occurred in four patients (20%) of the lung biopsies. Subaqueous decompression was instituted in three of the four patients to relieve this. The fourth patient was treated with needle aspiration on the first postoperative day and required no further decompression.

Hemoptysis developed postbiopsy in one patient (5%), but this was minimal and subsided during the day of the procedure, consisting only of bloodstreaked sputum.

Inadequate specimens were obtained in two patients (10%); however, at this point in time during the study, multiple biopsies were avoided.

No other complications resulted from the procedure. There was no serious morbidity and no deaths attributed to it.

Discussion

Three major methods of lung biopsy exist today, two of which have been demonstrated as suboptimally successful, and are not used extensively at this time, namely aspiration and cutting needle biopsy. Aspiration can be of diagnostic significance, but is of no value in diffuse pulmo-

TABLE 2—*Results and Complications of 20 Drill Lung Biopsies*

	ZaVala[1]		Steel[3]		Castillo[7]		Boylen[8]		Shrader	
	#	%	#	%	#	%	#	%	#	%
Number of Cases	47				100		75		20	
Number of Biopsies	50		119		113		75		20	
Adequate Biopsies	46	92	111	93		70		89*	18	90
Diagnostic	42	84	101	85		70		89*	17	85
Pneumothorax	16	32	31	26	46	40	32	43	4	20
Hemoptysis	4	8	14	12	9	8	5	7	1	5

*Earlier specimens in study were less diagnostic than the later 89%.

nary disease.[4] Biopsy with a cutting needle is useful for the diagnosis of diffuse disease, but the complication rate and incidence of inadequate biopsy[5,6] has led many practitioners to abandon the technique. Open thorocotomy remains the procedure of choice for many surgeons to obtain a diagnosis, especially for those patients with diffuse pulmonary disease.

The newer technique of trephine drill lung biopsy offers a safe and simple method for obtaining diagnostic histologic specimens. The procedure expends minimal time and effort by the surgeon, and in most instances, as demonstrated by the "one-try" biopsies in this study, a generous piece of tissue is obtained for the pathologist, usually 2 mm. in diameter and 2 to 4 cm. long. The rapid rotation (30,000 RPM in this study) of the drill allows it to cut through the tissue to be biopsied easily and without undue trauma. The resultant specimen is usually nonfragmented and is otherwise undisturbed and not distorted.

Contraindications for the procedure are considered to be:

1) Reasonable suspicion that the lesion is vascular,
2) The presence of severe pulmonary hypertension,
3) A bleeding diathesis,
4) Emphysematous bullae or blebs in the area of the lesion to be biopsied,[1] and
5) Previous penetrating injury of the chest at the site to be biopsied.[8]

The biopsies in this study were done primarily for diagnosis only. If the lesion was thought to be potentially resectable, biopsy was avoided, lest the biopsy cause local or distant tumor spread; however, some authors have not demonstrated this to be significant[4]. More noteworthy, perhaps, is the fact that thorocotomy will be avoided in a significant number of patients who undergo drill lung biopsy. In our study, no less than seven thorocotomies (35%) were avoided.

Our complication rate is similar to that of other authors (Table 2), and we believe is acceptable. A 20% incidence of pneumothorax is significant, but a chest tube for one or two days seems preferable to open thorocotomy.

Diagnostic specimens were obtained in 90% of the cases in this study. Rebiopsy was not attempted; however, it has been shown that more than one attempt can be made without undue hazard.[1,3]

Summary

The newer technique of trephine drill lung biopsy was performed percutaneously in 20 patients, 14 with diffuse disease, and six with localized lesions. Of the biopsies 85% were diagnostic and 90% yielded adequate tissue. Of the 20% of patients developing pneumothorax, 75% of these required decompression. Hemoptysis occurred in one patient (5%), but was minimal. It was concluded that trephine drill lung biopsy is a useful and safe technique for diagnosis of either diffuse or localized pulmonary lesions, and that open thorocotomy can be avoided using this technique in a highly significant percentage of patients.

REFERENCES

1. ZaVala DC, Bedell GN, Rossi NP: Trephine Lung Biopsy with a High Speed Air Drill, *J Thorac Cardiovasc Surg* 64:220, 1972.
2. Steel SJ, Winstanley DP: Trephine Biopsy for Diffuse Lung Lesions, *Br Med J* 3:30, 1967.
3. Steel SJ, and Winstan DP: Trephine Biopsy of the Lung and Pleura, *Thorax* 24:576, 1969.
4. Lauby VW, Barnett WE, Rosemond GP, et al: Value and Risk of Biopsy of Pulmonary Lesions by Needle Aspiration, *J Thorac Cardiovasc Surg* 49:159, 1965.
5. ZaVala DC, Bedell GN: Percutaneous Lung Biopsy with a Cutting Needle: An Analysis of 40 Cases and Comparison with Other Biopsy Techniques, *Am Rev Resp Dis* 106:186, 1972.
6. Youmans CR Jr, deGroot WJ, Marshall R, et al: Needle Biopsy of the Lung in Diffuse Parenchymal Disease: An Analysis of 151 Cases, *Am J Surg* 120:637, 1970.
7. Castillo G, et al: Trephine Drill Biopsy of the Lung, JAMA 228: 189, 1974.
8. Boylen TC, et al: High Speed Trephine Lung Biopsy: Methods and Results, *Chest* 63:59, 1973.

HIGUCHI INSURANCE AGENCY, INC.

(808) 531-7091

HONOLULU COUNTY MEDICAL SOCIETY'S
INSURANCE PROGRAM ADMINISTRATOR

TERM LIFE INSURANCE
DISABILITY INCOME INSURANCE
MAJOR HOSPITAL INSURANCE
DEFENDANTS REIMBURSEMENT INSURANCE



H. Tom Thorson

HEW withdrew their appeal of a US District Court ruling in favor of the Texas Medical Association in which the court ruled that nine PSRO areas for Texas were invalid and unlawful. TMA is seeking a single statewide PSRO under the auspices of TMA.

Program Teams for ten states have been set up to review utilization under Medicare. Plans have been announced to set up such teams in all fifty states. Teams are made up of four physicians, three other health professionals, and two consumer representatives.

Physician Owned insurance companies to write malpractice coverage have been set up in twelve states. One state (Tenn.) dissolved its JUP as a result. HMA well down the road toward final decision regarding the feasibility of a Hawaii owned company to do the same.

Malpractice Insurance remains number one concern. Physicians Protective Association organized under the leadership of Dr. Claude Caver met on September 1, for purposes of electing directors and establishing direction. Among those addressing the meeting were Rep. Ike Sutton, Rep. John Carroll, Past HMA Prexy Dr. Tom Frissell, Exec. Director Tom Thorson. Communications between PPA and HMA will continue.

HMA is proceeding with plans to file suit against the mandatory provisions of Act 219 requiring financial responsibility be proven before a license can be granted.

There are problems because there is no case law covering such a situation. Original legal research is involved, much of which is being done by AMA in Chicago. Court route will be through Federal Court. Date of filing is still not certain as it is absolutely essential that the case be complete before filing. Indications are that the logistic problems will prevent the Board of Medical Examiners from revoking any licenses before the case is ready.

In the meantime it must be emphasized that HMA is not taking any position on the question of whether a physician should be insured. The risk factor that faces each physician is best known to him and HMA believes strongly in the right of the physician to make that decision—that is why HMA is going to court. It is also important to remember that the right to practice medicine is carried in your *license* not in your insurance policy. Only if your license is taken away have you lost the right to practice. **SO—** if you receive any notice of license revocation, please contact HMA at once. Also notify the Board of Medical Examiners that you wish to have a hearing.

The sections of the law covering the issuance and continuance of license based on financial responsibility are equivocal. It is clearly stated that a license cannot be "issued" unless financial responsibility is established, but the right to "revoke" a license is permissive.

An interesting sidelight is on the cover of a publication called "BARRISTER" published by the American Bar Association, which states "Suing lawyers for incompetency is becoming a new source of legal fees" This should give us a clue.

HMA Annual Meeting is shaping up—remember the dates—October 24-October 29, at the Ilikai Hotel. Excellent CME programs with Category I credits. Early registration is urged. It is hoped that members will take a high degree of interest in the House of Delegates and Reference Committee meetings.

HMA in new office since August 21. Phone numbers remain the same but everyone should remember that HMA is no longer in the Mabel Smyth Building where it had been for over thirty years. HMA is now at 320 Ward Avenue—parking is adequate. Visit the new quarters and become familiar with the offices.

Citizens Against Noise are now located in their new quarters at 205 Merchant Street, Rm. 18. Joan Hayes their Director continues to campaign against excessive noise, work-related and otherwise.

Tumor Registry to move to 320 Ward Avenue in near future, hopefully before the end of September.

Emergency message—It has been reported that several attempts of extortion from doctor's families have occurred within the last few days. Procedure is: Doctor's wife may receive a telephone call advising that her husband is being held at gun point and that a messenger will be dispatched to her home and should give him all jewels and money in her possession. Recommendation: The doctor's wife immediately call her husband to verify situation and then promptly notify the police.



Act 219 HRS 1976

A year ago, it began to look promising, speaking of the medical liability (malpractice) insurance crisis. It looked like the State Administration and the Legislature both were thoroughly aware of the unacceptable astronomical rise in premium levels, plus the threat of all insurance carriers leaving the field in Hawaii. The problem was nation-wide, but we smugly thought our Hawaii experience—a good one—warranted a better shake than we were getting. It looked like, under pressure from the public, that *something* in the way of resolving the problem would come out of the legislative hopper.

Well before the Eighth Legislature convened, the Governor had appointed an Ad Hoc Committee-of-18 to develop bills that would remedy the situation and hold promise of enactment into law. The Hawaii Medical Association, however, had some early and tentative misgivings. It was given only three chairs on this committee: One went to a very able and dedicated worker-for-medicine, HMA's Executive Director Tom Thorson, to be sure, but only two M.D.'s, Albert Chun-Hoon and Alan Pavel, both in the same specialty field of orthopedics, both very capable, eloquent spokesmen, and certainly extremely knowledgeable on the subject. The HMA felt its negotiating force was small, but it made up in adequacy of brain-power and persuasion in the face of the 9 to 1 odds (vs. M.D.'s but 6 to 1 vs. HMA) against a mass of lawyers and insurance people.

Tom Thorson chaired a subcommittee of three, the other two being Miller and Hiraoka, that had to deal with the "residual market" of about 200 physicians who were licensed but carried no practice liability insurance. This is a surprising figure. The subcommittee came up with a report that spelled out clearly and emphatically that nothing be done in the way of legislation as regards those physicians and their choice NOT to protect themselves.

With only ten of the 18-man Ad Hoc Committee still left sitting, exhausted, the decision was made to make mandatory financial responsibility on the part of physicians who might participate in the benefits of the Patients' Compensation Fund, of course, but also in order to obtain or maintain a license to practice medicine and surgery. The latter proviso had come out of a casual reference in committee during a discussion on how the Patients' Comp Fund would be applied to the uninsured M.D.'s; it was picked up by the social scientists and lawyers and was never again allowed to drop out of the picture. The vote in committee was 4 to 3 in favor of retaining the proviso. Thorson and Ollie Burkett of the Hawaii Hospital Association fought long and hard to get it thrown out before the vote. Hiraoka joined those two in the nay vote. Three other members of the committee abstained, perhaps as a result of exhaustion or attrition, perhaps hoping that this would be a small concession in the face of issues looming large ahead, issues that would require even more strenuous fights to win. Many of the other members had gone home already.

The final draft of the "administration bill" composed by the committee-of-18 that was chaired by Wayne Minami, was generally the result of a consensus. HMA's three felt they had lost a few but won a lot, in terms of the whole bill. They had kept the HMA Council informed all along. The Council, too, went along with the bill as it evolved. The HMA published to its membership regularly these "happenings." (You were all informed! If you didn't read or didn't listen, don't blame the teachers in this large schoolroom of ours! We're all in this together. Let he who is blameless cast the first stone. While some of you were sitting on your fat asses, making bread, a few of us were working our asses off, and on your behalf!)

The bills went to the legislative hopper. In the Consumer Protection Committee of the House, Representative Roehrig led the fight to keep mandatory financial responsibility in. Again, it

was in the wee hours of a morning (Tom Thorson still there and lobbying) when there were only 7 members of the 12-man committee still present, 6 lawyers and Steve Cobb, that a vote was taken. It was 5 to 2 in favor of retention. The negative votes were cast by Ike Sutton and Steve Cobb, God bless 'em!

In the Senate's Judiciary Committee's "action" meeting, the item was again retained.

The proceedings of the Joint Conference Committee as regards those pro and those con is not a matter of public record. We do know, however, that Senator Pat Saiki spoke strongly against its retention. She, however, signed the CD 1 report, as did Senators Nishimura, Chong, Hara, O'Connor, Richard Wong, Mary George; Representatives Yamada, Cayetano, Cobb, Kondo, Stanley, Yap, Fong, Jr. and Medeiros. At that stage of the game it had become a matter of all-or-none. The Governor signed HB 2700-76 CD 1 into law in May.

HMA's Ad hoc committee met on May 20 and reviewed what we had gotten in terms of what we wanted. The committee felt it should continue to function as such, and the HMA Council later agreed, as it modified or corroborated the items that needed to be deleted from the law next go-around, or inserted.

In summary of HMA's long struggle, then, all of us who were involved on your behalf felt that Act 219, though imperfect, seemed to be a step in the right direction. It was not until Mr. Minami, Insurance Commissioner of the state and also head of the state department of regulatory agencies, came out with his questions and answers on August 10, and then his individual advisements to many of us physicians to the effect that we were not in compliance with the law for lack of adequate financial responsibility, as per regulations determined by himself, and that we MUST comply, that we came to realize how this new law would be applied.

By this time, it had also become apparent that despite the hoped-for enticement of the dampening effect of the conciliation panels, NO insurance companies other than the remaining Argonaut and CNA had re-entered the field in Hawaii, to provide competition and perhaps lower premiums therefore. On the contrary, Argonaut proposed RAISING the already high premiums by 84 to 87%. It even proved the need to do so actuarily, in front of the HMA Council. It offered only a 90-day policy, intimating a purpose to go even higher soon!

On top of all that, we learned at a late date that the state's surcharge would be 30%, to support the Patients' Comp Fund, and NOT a reasonable and acceptable 10% or less! And what's more, this computation would be made on the *new* base rates, ie, the old base plus 84%. The net effect will be to boost premiums by nearly 100%!

Many of us attending the information meeting of the Honolulu County Medical Society at which Minami and Wadlewski (Argonaut VP) spoke on August 17, were quite skeptical of Argonaut's change of heart (or figure) when it reduced the increase from 84% down to 47.1%. Our interpretation of this sudden change was that the premiums would be boosted in another 90 days!

We now know—and none of us really knew prior to the month of August—that:

(1) The promised reduction in premiums as a result of the enactment of 219, is a wisp of mist, not only dissipated, but with an opposite and cruel blow to physicians' and their patients' pocketbooks instead;

(2) No other insurance carriers have been attracted by the "Hawaii experience";

(3) The surcharge for the umbrella is not only an additional burden on most physicians, but a temptation, by its very size and presence, to more and bigger claims being made;

(4) And, finally, when the law says in Section 453-8: "Any license **may** (emphasis mine) be revoked, limited or suspended . . . for (14) Failure to maintain financial responsibility . . ." and the Director interprets that "may" as "must," the physicians of Hawaii suddenly see the light and realize they have been had.

Primarily because Act 219 is being interpreted in a way that would force all physicians either to take out prohibitively expensive insurance or to prove themselves rich enough to "mal-practice" with impunity, but also because it promises to escalate rather than diminish the cost of such insurance, it should be declared null and void forthwith.

J.I. Frederick Reppun, M.D.

EDITOR'S NOTE: *The officers of the HMA began investigating the constitutionality of the financial responsibility portion of the Bill as early as June 1.*

Watch Out! The Planners Will Get You!

We physicians can be so absorbed by our day-to-day problems that we overlook a gigantic danger now building up—a danger that could compound many of our problems and create new ones.

It's the Health Planning Act of 1974. This law is not just another governmental abstraction. It's not just a sauced-up rehash of Comprehensive Health Planning, the Regional Medical Program, and so forth.

On the contrary, it's the framework for a bureaucratic totalitarianism that could reshape the health-care system as we know it—including the responsibilities and expandability of hospitals and other facilities and even the rates they charge.

Moves to put doctors' offices and fees within the scope of the act are afoot in the Department of Health, Education, and Welfare, even though the AMA got them excluded from the law.

Certainly there must be planning. And certainly we must avoid costly overbuilding and overstocking of hospitals. Consider some of the ways, however, in which the Health Planning Act would flout the principles of rational planning, be a heavy expense in itself, and imperil the quality of care.

- The Secretary of HEW is to dominate five somewhat overlapping levels of federal, state and local authority. He is also to issue national health planning policy; appoint a national advisory council; approve state and local planning agencies and the funds they receive, and establish the criteria and procedures they use.
- Certificate-of-need legislation must be adopted in all states, as prescribed by the HEW Secretary. The need for all new institutional facilities and services must be certified; the need for all existent institutional services must be reviewed every five years. Practice-profile data from PSROs, plus the minority status of direct providers of care on local planning boards, could arbitrarily influence the expansion or continuation of services.
- Up to six states are to get federal grants to demonstrate rate regulation for heath services. This could become mandatory for all states and encompass physicians, if various planners get their way. The result of regulation is likely to be an obsession with cost at the expense of high-quality care.

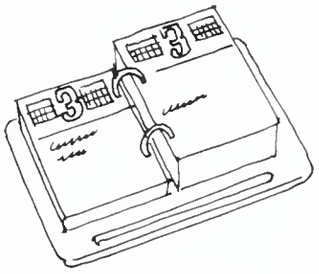
The AMA has petitioned the federal court to join the State of North Carolina in a suit aimed at voiding the law as unconstitutional. But adjudication can take many months. Meanwhile, physicians in many parts of the country are seeking adequate representation on local planning boards, showing up at public hearings pursuant to the law, and otherwise fighting the great potential danger. At the moment there is no other game in town.

AMA—Public Affairs Division

Announcement

To all members of the Medical Association and friends:

The Hawaii Medical Association Annual Banquet will honor H. Tom Thorson who is retiring as the Executive Director. This will be one of the few remaining opportunities for physicians of the Medical Association to say farewell to Tom. Please reserve your HMA Annual Banquet tickets now.



Continuing Medical Education

CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

Is the diagnosis ALCOHOLISM?

Time proven alcoholism treatment — formerly available only at Mainland centers — now offered at Post Hospital Recovery Unit, Hilo Care Center.

- A basic, 28-day in-patient program of motivational counseling
- Therapists carefully selected and themselves recovered alcoholics
- Hawaii licensed professional consulting staff in psychiatry, psychology and family medicine
- Privacy, seclusion, total confidentiality in modern facility, beautiful setting

Direct inquiries to:
Marilee Fletcher, Associate Director,
Post Hospital Recovery Unit,
HILO CARE CENTER
944 West Kawailani Street
Hilo, Hawaii 96720 Phone (Hilo) 959-9151

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m.

John A. Burns School of Medicine

1. University Grand Rounds in Psychiatry, Tuesdays, 10:00-11:30 a.m. at Queen's or St. Francis. (Contact John F. McDermott, Jr., M.D. or Wen-Shing Tseng, M.D. for further info)

Kaiser Hospital

(Contact CME Dept. for further information)

Kauikeolani Children's Hospital

1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program

Kapiolani Maternity Hospital

1. Grand Rounds, Wednesdays, 7:30-8:30 a.m.
2. Resident Conference, Tuesdays (except 1st), 1:00 p.m.
3. Ob-Gyn Department Meeting, 1st Tuesday, 1:00 p.m.
4. UH Seminars, Wednesdays, 3:30 p.m.
5. Perinatal Conference, Thursdays, 3:30 p.m.
6. Tumor Board, 1st & 3rd Fridays, 1:00 p.m.
7. Oncology Conference, 4th Friday, 1:00 p.m.
8. Visiting Professor Program

Kuakini Hospital

1. Hematology Rounds, Monday, 1:00-2:00 p.m.
2. Gastroenterology, Tuesday, 8:00-9:00 a.m.
3. Oncology Conference, Thursday, 8:00-9:00 a.m.
4. Endocrine Conference, 2nd Wednesday each month, 1:00-2:00 p.m.
5. Medical Statistics, 3rd Tuesday each month, 1:00-2:00 p.m.
6. Renal Conference, Wednesdays, 1:00-2:00 p.m.
7. Visiting Professor Program
8. Infectious Disease Conference, Thursdays, 1:00 p.m.

The Queen's Medical Center

1. Medical Grand Rounds, Every Friday, 8:00 a.m., Kam Auditorium
2. Surgical Conferences, 1st Tuesday, 4:30 p.m., Kam Auditorium
 Medical-Surgical Conferences, 2nd Tuesday, 4:30 p.m., Kam Auditorium
 Surgical CPC, 3rd Tuesday, 4:30 p.m., Kam Auditorium
 Basic Science Lectures, Every Wednesday 7:15 a.m., Surgical Conference Room
3. Ob/Gyn Conferences, 2nd and 4th Mondays, 12:30 p.m., Blood Bank Conference Room
4. Pathology Conferences, Every Wednesday, 7:30 a.m., Blood Bank Conference Room
5. Pediatric Grand Rounds, 2nd Wednesdays, 12:30 p.m., Harkness 128
6. Orthopedics Conferences, Every Friday (except the last), 7:30 a.m., Blood Bank Conference Room
7. Tumor Conferences, Last Tuesday, 7:30 a.m., Kam Auditorium
8. Urology Grand Rounds, as designated
9. Psychiatry CME Conference, as designated
10. Neurology/Neurosurgery Conference, as designated

Hickam Clinic

1. Clinical Correlation Conference, 1st Thursday, 11:00 a.m.
2. Didactic—our staff, 2nd Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, 3rd Thursday, 11:00 a.m.
4. Radiology Conference, 4th Thursday, 11:00 a.m. (Contact H.P. Stern, Capt, M.D., MC at 449-9742)

St. Francis Hospital

1. Medical Grand Rounds, Tuesday (4th & 5th) 12:30-1:30 p.m. Sull. IV Classroom
2. Un. Medical Grand Rounds—Tuesday 12:30-1:30 p.m. Mabel Smyth Bldg.
3. Surgical Grand Rounds, Fridays (except 4th) 7:30-8:30 a.m.
4. Tumor Conference, Mondays, 7:30-8:30 a.m.
5. Visiting Professor Program
6. Clinical Pathology Topics, Mondays, 10:00-11:00 a.m.
7. Microslide Conferences, Tuesdays, 8:30-9:30 a.m.
8. Bone Marrow Pathology, Tuesdays, 2:00-3:00 p.m.
9. Basic Science Review & Research Conference, Thursdays, 1st & 3rd, 8:00-9:00 a.m.
10. EENT Teaching Rounds, Tuesday (1st) 7:00 a.m.
11. Psychiatry for the Non-Psychiatrist, Tuesdays (2nd) 12:00-1:00 p.m.
12. Surgical Mortality & Morbidity Conference, last Friday, 7:30-8:30 a.m.
13. Saturday Teaching Rounds, Saturdays (except 4th) 7:30-8:30 a.m.

Straub Clinic & Hospital

1. Medical Grand Rounds, first Thursday, 7:00 a.m.
2. Surgical Mortality & Morbidity, 4th Thursday, 7:00 a.m.
3. Quarterly Professional Staff Meetings, (Jan., Apr., Aug., Nov.), 4th Monday, 7:30 p.m.

Wahiawa General Hospital

1. Noon Seminars, 2nd Friday & 4th Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:30 p.m. & 2nd Wednesday, 12:30 p.m. of each month in the 320 Ward Ave. Building. Contact HMA Office as dates are subject to change.

Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817
At: Honolulu County Medical Society and Local Hospitals, Honolulu
Type: 1, 1 hr/day, 1 day/mo from 12 mos
Fee: None Methods: AV, O, Pan
Dates: All yr, 12 hrs instruction

Telephone Task Force—Hawaii (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817
Type: 1, 1 hr/day, 1 day/mo for 8 mos
Fee: None Methods: AV, Clin C, O, Pan, R
Dates: Arranged; 8 hrs instruction

SPECIAL EVENTS

Sept. 23, 1976-Aug. 25,1977	Telephone Task Force—Maui (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817 Type: 1, 1 hr/day, 1 day/mo for 12 mos Fee: None Methods: AV, Clin C, O, Pan, R—12 hrs instruction.
Sept. 25-Oct. 1	Cardiology—1976 (#120) University of Southern California School of Medicine, 2025 Zonal Avenue, Los Angeles 90033 At: Mauna Kea Beach Hotel, Kamuela, Hawaii Of interest to: Internists, Cardiologists Approximate # hours: 25 Coordinator: Willis Hurst, M.D., Professor & Chairman, Department of Medicine, Emory University

	This week is designed to bring the internist and cardiologist up-to-date in current problems of cardiology.
October 3-8	VI Asian Pacific Congress of Cardiology at the Sheraton-Waikiki; contact Dr. Morton Berk for further information at 537-2211.
Oct. 18-22	American College of Physicians—Hormonal Aspects of Internal Medicine; Ilikai Hotel; Director John Kim, M.D. Credit 19½ hours Category 1. Contact: Registrar, ACP, 4200 Pine St. Philadelphia, Pa. 19104
Oct. 25-29	Hawaii Medical Association Annual Meeting; Ilikai Hotel; contact Bess Chang for further information at 536-7702.
Oct. 26	Fireside Conference (B) Hawaii Thoracic Society, 245 N. Kukui St., Honolulu 96817 Co-sponsor: American Lung Assn. of Hawaii At: Ilikai Hotel, 1777 Ala Moana, Honolulu 96815 Type: C, 1 day Fee: None Methods: AV, Lec, O, Pan 2½ hrs instruc.
Oct. 26, 1976	"Evaluation & Management of Acute Respiratory Failure"—Minicourse—Wahiawa Gen. Hosp.; Medical Staff. 12:30 lunch. mtg., 6:00 p.m. dinner mtg. Cat. 1—4 hrs. credit. Contact Richard P. Tesoro, M.D.
Oct. 26-Nov. 2	Visiting Professorship Program (B) Hawaii Thoracic Society, 245 N. Kukui St., Honolulu 96817. Co-sponsor: American Lung Association of Hawaii At: Major hospitals on Oahu, Kauai, Maui & Hawaii Type: CC Fee: None Methods: AV, BR, Lec, O 6 hrs instruction
Oct. 30-Nov. 6	Evaluation of Neoplastic Lymphoproliferative Disorders University of Southern California School of Medicine, 2025 Zonal Ave., Los Angeles 90033 At: Hawaii—Mauna Kea Hotel, Mauna Kea Type: C, 7 days 42 hrs instruction
Nov. 4-5, 1976	"Biofeedback; Bodily Control & Therapeutic Application," 6:30 p.m.-10 p.m. ea. evening. Cat. 1—3½ hrs. cred. Reg. thru Division of CME—U of H; $30.00. Contact: Dr. John Watson.
Nov. 17-24, 1976 & March 13-19, 1977	Diving Medicine (B-50) Undersea Med. Soc., c/o Professor Edward Beckman, University of Hawaii Conference Center, 1960 East-West Road, Honolulu, 96822 At: Kailua Kona Type: C, 8 days Fee: $200 Methods: AV, OP, PP, Lec, O, Sem 25 hrs instruction

The seminars on "Sexual Counseling: Office Management of Sexual Problems" sponsored by the ACOG and University of Hawaii will be held on the following dates: (20 hrs. credit)

October 18-22 December 20-24
November 22-26

For further information, write to: American College of Obstetricians & Gynecologists, Department of Continuing Education, 1.E. Wacker Drive, Suite 2700, Chicago, IL 60601

OUT OF STATE

For information on any out-of-state programs or courses, refer to August 11, 1975 Supplement to JAMA or call the HMA Office.



WAIALAE IKI IV

LAST OF ITS KIND IN THIS AREA!

Here "at the top . . ." overlooking the grandeur of the valley and sea below is a lifestyle that's second to none. To top it off, Waialae Iki IV is your last chance to custom build and assure a sweeping view from Diamond Head to Koko Head. Work with our architects, your home design or ours, or a combination of ideas . . . let's talk about your home on the hill in Waialae Iki IV.

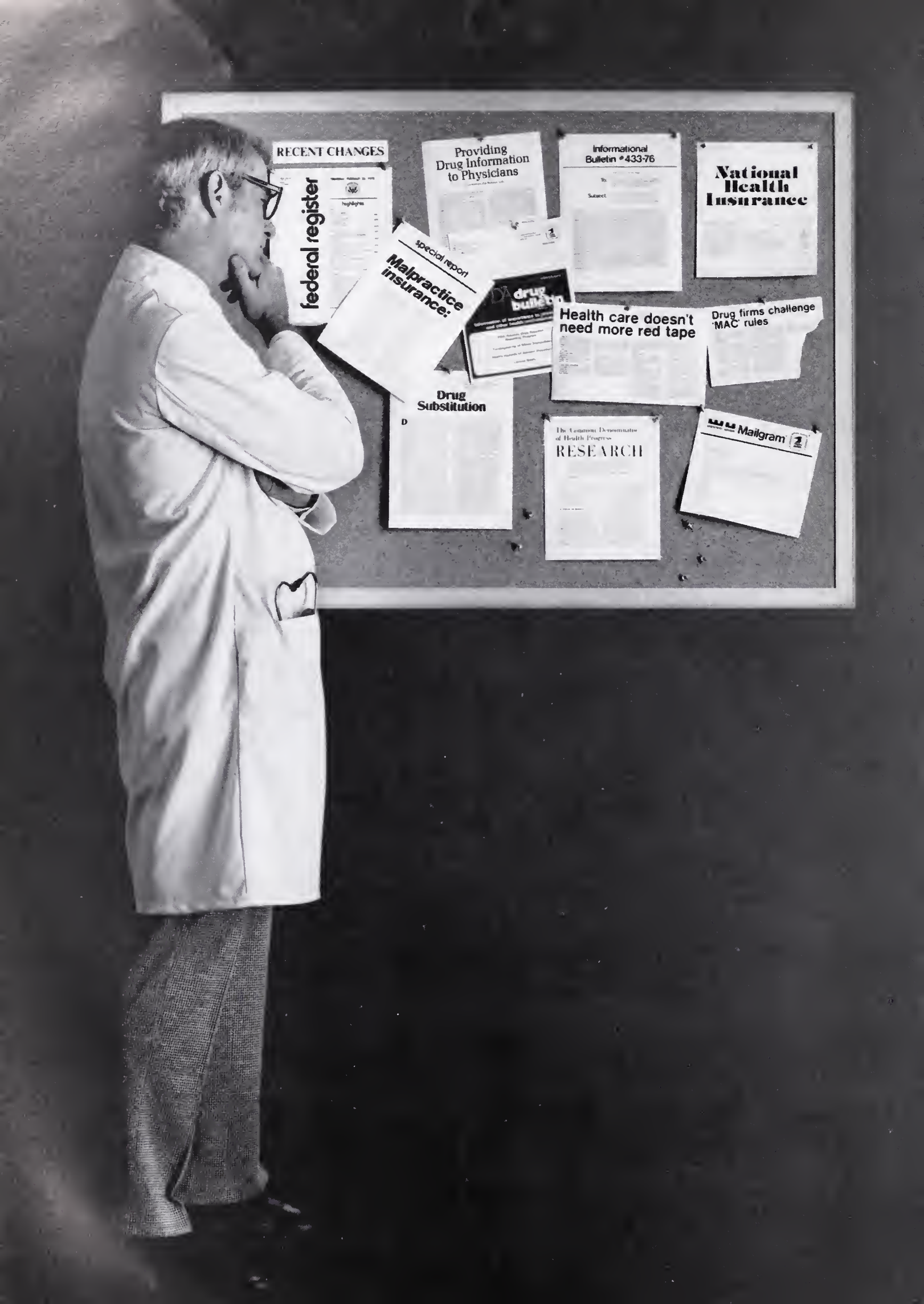
From **$163,400** including heated pool.
Leasehold.

Model home open 7 days a week.
Weekends, 10 AM to 5 PM,
Weekdays, 1 to 5 PM.

New models with heated pools soon to be constructed.



Herbert K. Horita Realty, Inc. Kalihi Phone: 847-4241/Waimalu Phone: 487-1561/Waikiki Phone: 922-3377


RECENT CHANGES
federal register
Providing Drug Information to Physicians
Informational Bulletin #433-76
National Health Insurance
special report
Malpractice insurance:
drug bulletin
Health care doesn't need more red tape
Drug firms challenge 'MAC' rules
Drug Substitution
The Common Denominator of Health Progress
RESEARCH
Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

Hawaii Academy of Family Physicians' Newsletter

J. J. Frederick Reppun, M.D.

New Student Members—Joining us from the UH School of Medicine are: **Merrill Chandler** '79, **Debra Hamburg** '79, **Curtis Kamida** '79, **Joan Magner** '80, **David Miyauchi** '80, **Kenneth Nakamura** '79, **James Popplewell** '79, **Clarice Sackett** '79, **Randolph Shiraishi** '79, and **Stephen Wee** '80. Welcome aboard!

News of Members—Jonathan Cho MD '76 is in Orange, Calif.; **Dale Wicklund** MD '76 has an APO San Francisco address: **Grace Crittenden** MD '76 is in Atherton, Calif.; **Benedict Diniega** MD '76 remains in Hawaii; **Mike Hase** MD has returned to the Islands and has opened an office in the Kahala Professional Building and is applying for membership in the chapter; **Tom Cahill** MD has become a Fellow, AAFP; **Don Hall** is now at Letterman Army Medical Center; **Milton Howell** of Hana, Maui was quoted in the Advertiser (8/3/76) as being in favor of the National Parks Service plan to develop the Ohe'o or Seven Pools area but NOT to make it inaccessible to visitors. "Tourism is here to stay," Milt stated; **Gerald Yorioka** sent in his last letter-to-the-editor, perhaps, (SB 9/4/76) in which he felt the malpractice insurance climate was becoming so intolerable that he was moving to a "safer" state: Whitbey Island, Washington." . . . the lawyers thank the legislature. The insurance companies thank you. And I say goodbye." Sorry, Gerald, we'll miss your erudite pen!

AMA News—John Budd, member AAFP, has been chosen as President-elect of the AMA!

August 21 Dinner Meeting—at **Don Farrell's** in Heeia was well attended; Bob Thune MD, Kaiser allergist and Rita Brennan RN of their staff gave an informative presentation. In lieu of a regular Council meeting on Thursday at noon, the Council met to authorize payment to the two delegates, **Lafferty** and **Reppun,** for their Boston trip in September, and also to provide monetary support for Felix' campaign to run for one of the Director, AAFP slots. Hawaii Del Monte Corp. chief Frank Dillard is providing 40 pineapples, fresh, for free, for the Hawaii hospitality suite, and United Airlines will ship them to Boston for us for free. Appreciative kudos to them! The Council voted unanimously to waive the By-Laws pending revision, to allow entry as members Doctors of Osteopathy. **Dave Swanson** MC USA was elected to replace **Don Hall** as councillor; **Dave Livingston** was proposed to replace **Gerald Yorioka.**

Obits—The Academy, the Chapter, and the community lost a long-time family physician who, at the age of 77, was still practicing up to the time he was taken by ambulance to Queen's CCU on 21 August; **Henry Dickson** died on 1 September, the day after he was moved out of CCU to a Pauahi floor. Our condolences to his wife and family. The impact of his presence was always felt.

Cat. P—Coming up: "On Life and Death" Thursday 21 October—the Auxiliary to HCMS; 25-29 Oct. the 120th HMA Ann. Scient. Meeting; 3-8 Oct. 6th Asian-Pacific Congress on Cardiology; 8-12 March 1977 Sports Medicine.

Letters to the Editor, *continued from 255*

The purpose of this letter is to request that the Society instead espouse and openly organize a program to encourage a substantial number (hopefully all) of its members to agree by signature to refrain from submitting "evidence of financial responsibility" to the State Board of Regulatory Agencies. This form of activity would constitute an excellent example of non obstructive, constructive civil disobedience which would force the administration and legislature to restudy the aims which somehow became twisted into what Act 219 now represents. It would produce an impasse which would injure no one, for we could all go on practicing and providing the services we must without change in insurance status. I today spoke with Mr. Cliff Miyoi and he noted no provision in the law for compliance with respect to submitting evidence of financial responsibility, except for 'due process' for dealing with each non-complier. The exact methods for dealing with non-compliers has not yet been worked out by the Board of Medical Examiners.

Due process would be an endless procedure. If, in fact, the State could expedite such hearings it would be mandating a large group of physicians to stop practicing medicine which, if the number

WILLIAMS MORTUARY

"CHAPEL OF THE CHIMES"

1076 S. Beretania St., Phone 537-2587 **Ample Parking Adjoining Mortuary**

OVER A CENTURY OF SERVICE

"Service measured not by gold but by the Golden Rule"

MEMBER

National Selected Morticians, National Funeral Directors Association,
Order of the Golden Rule, Hawaii Funeral Directors Association

A NON-ASPIRIN ALTERNATIVE TO COMPOUND ANALGESICS

Documented potency: Double-blind clinical studies[1,2,3] demonstrate the efficacy of TYLENOL® acetaminophen Extra-Strength capsules (500 mg.) in the control of moderate to severe pain.†

No aspirin side effects: Unlike most compound analgesics, TYLENOL Extra-Strength capsules contain no aspirin; they therefore minimize the risk of side effects often associated with aspirin, such as gastric irritation, hemostatic disturbances and allergic reactions.

So when your patients with minor conditions need greater analgesic strength than that provided by regular doses of the mild analgesic products, recommend or prescribe TYLENOL Extra-Strength capsules.

1. Hopkinson, J.H. III, et al.: Curr. Ther. Res. *16*:194 (Mar.) 1974.
2. Berry, F.N., et al.: Curr. Ther. Res. *17*:361 (Apr.) 1975.
3. Smith, M.T., et al.: Curr. Ther. Res. *17*:452 (May) 1975.

Precautions and Adverse Reactions:
If a rare sensitivity reaction occurs, the drug should be stopped.
TYLENOL® acetaminophen products have rarely been found to produce any side effects.
Available in bottles of 50.

†Episiotomy was used as a model to evaluate analgesia.

Recommend or prescribe 2 caps t.i.d. or q.i.d.*

*No more than a total of 8 capsules in any 24-hour period.

© McN 1976

McNEIL McNeil Laboratories, Inc., Fort Washington, Pa. 19034

TYLENOL® acetaminophen EXTRA-STRENGTH CAPSULES 500 mg.



of physicians involved was sufficient, would be impossible by virtue of the severity and deprivation of services it would cause.

The situation is a perfect one. I would hope our Medical Society has the good sense and cohesiveness to seize upon this opportunity for the good of every citizen of the State and in hopes of rectifying the poor results that have thus far been achieved in the attempt to deal with medical liability insurance problems.

PHILIP R. FOTI, M.D.



New Members



Edward L. Beckman, M.D.
PHYSIOLOGY AND DIVING MEDICINE
1960 East West Road
Honolulu, Hawaii 96822



P. Gregory Bohart, M.D.
GENERAL PRACTICE
USPHS Clinic
P.O. Box 1410
Honolulu, Hawaii 96807



Kevin C. Chen, M.D.
OBSTETRICS & GYNECOLOGY
46-132 Kahuhipa Street
Kaneohe, Hawaii 96744



Charles Hamasaki, M.D.
OTOLARYNGOLOGIST
670 Ponahawai Street
Hilo, Hawaii 96720



Karen S. Y. Ho
STUDENT
96-655 Aiea Heights Drive
Aiea, Hawaii 96701

In Memoriam



Joseph W. Lam M. D.
1901-1976

Joe Lam died peacefully in his sleep on his 75th birthday, June 14, 1976.

His wife of 38 years, Ardith, had gone about her quiet morning chores, looking in on Joe occasionally and allowing him to sleep late, as was his wont. A sudden gust of wind slammed his bedroom door shut. As she went to investigate, wondering why it had not wakened him, she found Joe on his side in bed, his hands together as in prayer, his soul departed.

In private services, his ashes and a single lei of Pikake were strewn on the waters of Kaneohe Bay from his favorite outboard fishing boat. The Trade winds were brisk and the waters choppy; small craft warnings were out. But as the brief service was performed, there was a sudden drop in the wind's force and the waters calmed, as the solitary beautiful lei drifted away.

Joe had oesophageal cancer. In January, this year, at the annual meeting of the Hawaii Academy of Family Physicians, Joe was eulogized in *absentia:*

> "We have here a suitable occasion in which to honor one of our long-time members—Joseph Lam M.D.
>
> "Joe could not be here tonight; he is suffering too much from iatrogenic effects. Joe discovered in himself an oesophageal Ca last November and elected to undergo treatment by his colleagues with the Linear Accelerator at St. Francis Hospital. Many of us are well aware that treatment is betimes worse than the disease.
>
> "We would like to honor Joe in *absentia*, therefore, and offer this testimonial to him, his wife Ardith and their family.

"Joe was born in 1901. His parents came from China in the 1860's. Dr. Fred Lam senior, father of our colleague present here tonight, Fred Jr., was Joe's brother. Fred Sr. died last year; he was our fellow member too. Richard Lam M.D. is another nephew.

"Joe graduated from St. Louis High School and went on to the University of Michigan college and school of medicine, receiving his MD in 1927. He spent three months working at St. Francis Hospital before starting his internship at Queen's, where he served from January 1928 to July 1929. He then went into private practice.

"In 1931 Joe became full-time Director of the Palama Settlement Out-patient Clinic. He held that position for 13 years, until 1944, when he opened an office for the private practice of medicine on the Ewa-makai corner of Liliha and Vineyard. His uncle gave him the use of three rooms upstairs. He continued to serve the Palama Clinic on a part-time basis and was the first to perform vasectomies and introduce IUD's as contraceptives back in the days when doctors were not supposed to do those things—especially in regard to 'public health.'

"In 1944 a new building was put up on that corner and Joe obtained the ground floor corner suite. He has recently put up a sign announcing the closing of his practice. He has turned it over to a new Internist in our community.

"Joe has been a member of the Academy for 24 years (September 1951) and was one of the charter organizers of this chapter. He has been in the practice of medicine for 48 years in Honolulu. He is a member of the Honolulu County Medical Society, the Hawaii Medical Association and the AMA. This is a physician colleague who has served humanity in our community faithfully and well. He deserves our respect and love.

"We would like Joe and Ardith to accept this message from us: His generalist colleagues—that we wish him ALOHA. I can assure you from personal knowledge that Joe Lam faces his future with equanimity, being at peace with his fellow man and with God."

The Hawaii Medical Association together with its component County Medical Societies join the Hawaii Academy of Family Physicians in extending to Joe's family their condolences and their Aloha.

J. I. Frederick Reppun, M.D.

"Our Angels"

	Page
Ayerst	
Mysoline	280, 281, 282
Century Pacific, Inc.	
Jockey Club	277
Hawaii Medical Leasing	254
Herbert K. Horita Realty, Inc.	
Waialae Iki IV	271
Higuchi Insurance Agency	265
Hilo Care Center	269
Eli Lilly and Company	
Keflex	260
McNeil Laboratories, Inc.	
Tylenol	275
Pharmaceutical Manufacturers	
Association	272, 273
Roche Laboratories	
Dalmane	278, 279
Valium	252, 253
Roerig	
Marax	256, 257, 258
Sen Company	259
Williams Mortuary	274

OWN A PIECE OF THE STRIP!

JOCKEY CLUB

IN LAS VEGAS

Las Vegas' most beautiful condominium resort on the Strip next to the Dunes—across the street from the MGM and the Aladdin Hotel.

Compare your pluses:

Tax shelter
Maximum profit potential
No recession on the Strip

Fortunes are made by being at the right place at the right time. COMPARE this investment with any condominium in Hawaii. *There are over 12,000 unsold units.* (1976 Bank of Hawaii report)

Now is the time to get in on the ground floor before the Jockey Club Casino opens! Single and Hui purchases welcome.

One Bedroom Suites from $52,000

CENTURY PACIFIC, INC.
REALTORS

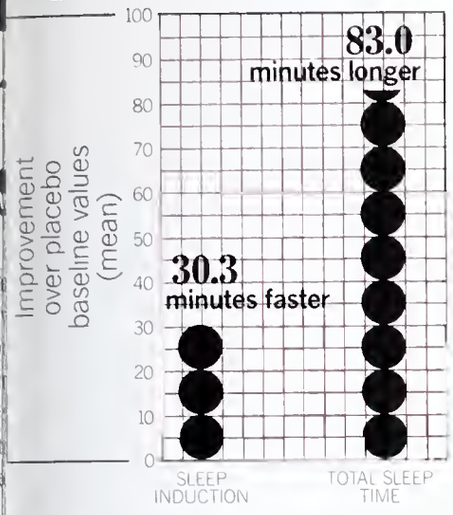
1027 A Bishop St. Honolulu
Ph. 521-6987

The ultimate objective test: sleep laboratory proof of effectiveness . . . now in geriatric insomnia patients

Six female insomniacs, ranging in age from 67 to 82 years received Dalmane (flurazepam HCl) for seven consecutive nights in the sleep research laboratory.[1] Improvement over pre-treatment baseline levels was significant for sleep induction and sleep maintenance ($p<.05$). And the greater the sleep problem in these patients, the better the effect with Dalmane (significant correlation at $p<.01$ level).



Elderly insomniacs fell asleep faster, slept longer[1]



Results expand and confirm objective proof of efficacy in younger adults with insomnia

The effectiveness of Dalmane (flurazepam HCl) was demonstrated in earlier studies of 32 younger adults with trouble falling asleep, staying asleep or sleeping long enough.[2] On average, in these studies, Dalmane induced sleep within 17 minutes and provided 7 to 8 hours of sleep, at the same time reducing number of nighttime awakenings.

Relative safety, even in patients on warfarin

Morning "hang-over" has been relatively infrequent with Dalmane. And no unacceptable fluctuation in prothrombin time has been reported in warfarin patients on Dalmane.[2,3] The usual adult dosage is 30 mg *h.s.*; in elderly and debilitated patients, limit initial dosage to 15 mg to help preclude oversedation, dizziness or ataxia.

Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

REFERENCES:

1. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
2. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
3. Robinson DS, Amidon EL: Interaction of benzodiazepines with warfarin in man, in *The Benzodiazepines*, edited by Garattini S, Mussini E, Randall LO. New York, Raven Press, 1973, p. 641

New evidence proves insomnia relief in elderly patients

Dalmane®
(flurazepam HCl) ℞

One 15-mg capsule *h.s.*—initial dosage for elderly or debilitated patients.
One 30-mg capsule *h.s.*—usual adult dosage
(15 mg may suffice in some patients).

For all common types of insomnia

ROCHE
ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110


w Xx Yy Zz
Art
mail
$\frac{2}{3} \times \frac{3}{4} = \frac{6}{12} =$
$\frac{4}{5} \div \frac{7}{8} = \frac{32}{35}$
$\frac{4}{7} + \frac{3}{7} =$

The vulnerable ages

The first epileptic seizure is most likely to occur during early childhood and at the onset of puberty

About 9 out of 10 epileptics experience their first seizure before the age of 20—with the highest incidence between 5 and 7, when children start school, and at the onset of puberty, a time of physiological and psychic turmoil.[1] The most common type, grand mal, occurs in approximately 75% of epileptic children,[1] and more than 50% of patients who suffer initially from petit mal develop grand mal seizures before they reach the age of 16.[2]

Mysoline (primidone) for control of grand mal, psychomotor and focal epilepsy

At the onset and afterwards— used alone or as concomitant therapy, MYSOLINE may reduce the frequency and severity of major motor seizures—or even eliminate them. *Excellent* for control of grand mal. Valuable for control of psychomotor[1,3,4] and focal epilepsy as well.[5]

Add Mysoline when control with other anticonvulsants is inadequate—As concomitant therapy, MYSOLINE can improve seizure control in grand mal and psychomotor epilepsy. The combined use of phenobarbital, diphenylhydantoin, and MYSOLINE may have additive anticonvulsant effects without additive side effects.[6]

Change to Mysoline when other anticonvulsants fail— A changeover to MYSOLINE is frequently warranted when other anticonvulsants must be discontinued because of important side effects, or when grand mal seizures are refractory to phenobarbital, with or without diphenylhydantoin.[7]

Ayerst®

Mysoline® (primidone)

Tablets 250 mg.
50 mg.
Suspension 250 mg./5 cc.

May be the start of a better life for the epileptic

See following page of advertisement for prescribing information.

Mysoline® (primidone)

may be the start of a better life for the epileptic

initial and maintenance therapy for
grand mal, psychomotor and focal epilepsy

BRIEF SUMMARY
(For full prescribing information, see package circular.)

MYSOLINE® Brand of PRIMIDONE
Anticonvulsant

ACTIONS: MYSOLINE acts on the central nervous system to raise seizure threshold or alter seizure pattern. The mechanism(s) of action of anticonvulsant drugs is not known.

Primidone has anticonvulsant activity *per se*. In addition, its two metabolites possess anticonvulsant qualities. The major metabolite is phenylethylmalonamide (PEMA); the other is phenobarbital. In addition to its own anticonvulsant potential, PEMA potentiates phenobarbital.

INDICATIONS: MYSOLINE, either alone or used concomitantly with other anticonvulsants, is indicated in the control of grand mal, psychomotor, and focal epileptic seizures. It may control grand mal seizures refractory to other anticonvulsant therapy.

CONTRAINDICATIONS: Primidone is contraindicated in: 1) patients with porphyria and 2) patients who are hypersensitive to phenobarbital (see ACTIONS).

WARNINGS: The abrupt withdrawal of antiepileptic medication may precipitate status epilepticus.

The therapeutic efficacy of a dosage regimen takes several days before it can be assessed.

Use in pregnancy. Recent reports strongly suggest an association between the use of anticonvulsant drugs by women with epilepsy and an elevated incidence of birth defects in children born to these women. Reference has been made to primidone in several cases in which it was used *in combination* with other anticonvulsants; but its teratogenicity has not been conclusively demonstrated. The possibility exists that other factors, *e.g.*, genetic factors or the epileptic condition, may contribute to the higher incidence of birth defects. The data also indicate that the great majority of mothers receiving anticonvulsant medication deliver normal infants.

Anticonvulsant drugs should not be discontinued in patients in whom the drug is administered to prevent major seizures because of the strong possibility of precipitating status epilepticus with attendant hypoxia and risk to both mother and the unborn child.

When the nature, frequency, and severity of the seizures do not pose a clear threat to the patient, good medical practice requires that the physician weigh the expected therapeutic benefit of anticonvulsant therapy against possible risk on an individual basis.

Neonatal hemorrhage, with a coagulation defect resembling vitamin K deficiency, has been described in newborns whose mothers were taking primidone and other anticonvulsants. Pregnant women under anticonvulsant therapy should receive prophylactic vitamin K_1 therapy for one month prior to, and during, delivery.

The physician should weigh all of the foregoing considerations when treating and counseling epileptic women of childbearing potential.

PRECAUTIONS: The total daily dosage should not exceed 2 Gm. Since MYSOLINE therapy generally extends over prolonged periods, a complete blood count and a sequential multiple analysis-12 (SMA-12) test should be made every six months.

In nursing mothers: There is evidence that in mothers treated with primidone, the drug appears in the milk in substantial quantities. Since tests for the presence of primidone in biological fluids are too complex to be carried out in the average clinical laboratory, it is suggested that the presence of undue somnolence and drowsiness in nursing newborns of MYSOLINE-treated mothers be taken as an indication that nursing should be discontinued.

ADVERSE REACTIONS: The most frequently occurring early side effects are ataxia and vertigo. These tend to disappear with continued therapy, or with reduction of initial dosage. Occasionally, the following have been reported: nausea, anorexia, vomiting, fatigue, hyperirritability, emotional disturbances, sexual impotency, diplopia, nystagmus, drowsiness, and morbilliform skin eruptions. Occasionally, persistent or severe side effects may necessitate withdrawal of the drug. Megaloblastic anemia may occur as a rare idiosyncrasy to MYSOLINE and to other anticonvulsants. The anemia responds to folic acid, 15 mg. daily, without necessity of discontinuing medication.

DOSAGE AND ADMINISTRATION: The average adult dose is 0.75 to 1.5 Gm. per day. The initial dose is 250 mg. Increments of 250 mg. are added, usually at weekly intervals, to tolerance, or therapeutic effectiveness, up to daily doses not exceeding 2.0 Gm. A typical dosage schedule for the introduction of MYSOLINE (primidone) is as follows:

Adults and Children Over 8 Years of Age

1st Week 250 mg. daily at bedtime	*2nd Week* 250 mg. b.i.d.
3rd Week 250 mg. t.i.d.	*4th Week* 250 mg. q.i.d.

In children under 8 years of age, maintenance levels are established by a similar schedule, but at one-half the adult dosage. It is best to begin with 125 mg., with gradual weekly increases of 125 mg. a day, to a daily total usually between 500 mg. and 750 mg.

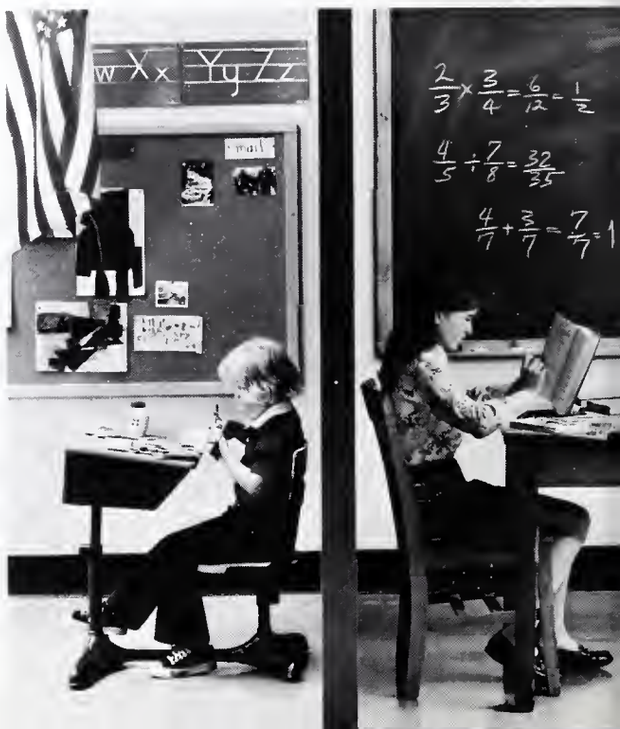
In patients already receiving other anticonvulsants: MYSOLINE should be gradually increased as dosage of the other drug(s) is maintained or gradually decreased. This regimen should be continued until satisfactory dosage level is achieved for combination, or the other medication is completely withdrawn. When therapy with this product alone is the objective, the transition should not be completed in less than two weeks.

MYSOLINE 50 mg. Tablet can be used to practical advantage when small fractional adjustments (upward or downward) may be required, as in the following circumstances:

- for initiation of combination therapy
- during "transfer" therapy
- for added protection in periods of stress or stressful situations that are likely to precipitate seizures (menstruation, allergic episodes, holidays, etc.)

HOW SUPPLIED: MYSOLINE *Tablets*—No. 430—Each tablet contains 250 mg. of primidone (scored), in bottles of 100 and 1,000. Also in unit dose package of 100. No. 431—Each tablet contains 50 mg. of primidone (scored), in bottles of 100 and 500. MYSOLINE *Suspension*—No. 3850—Each 5 cc. (teaspoonful) contains 250 mg. of primidone, in bottles of 8 fluid-ounces.

References: 1. Livingston, S.: Comprehensive Management of Epilepsy in Infancy, Childhood and Adolescence, Springfield, Ill., Charles C Thomas, 1972, pp. 6, 7, 584. 2. Grossman, H.J.: Ill. Med. J. *135*:260 (Mar.) 1969. 3. Scholl, M.L., in Conn, H.F.: Current Therapy 1973, Philadelphia, Saunders, 1973, pp. 675-7. 4. Metrick, S.: C.M.D. 37:49 (Jan.) 1970. 5. Forster, F.M.: Med. Clin. North Am. 47:1579 (Nov.) 1970. 6. White, P.T.: Wis. Med. J. 68:178 (Apr.) 1969. 7. Millichap, J.G.: Drug Ther. *1*:15 (Oct.) 1971.



Ayerst®
AYERST LABORATORIES
New York, N.Y. 10017

OCTOBER, 1976
VOL. 35, NO. 10

Hawaii Medical Journal

CONTENTS

Cancer Mortality Among Japanese in Hawaii Comparison of Observed and Expected Rates Based on Prefecture-of-Origin in Japan 293
Abraham Nomura, M.D., and Tomio Hirohata, M.D.

Multidisciplinary Team Approach to Patient Education in Hypertension 298
Azucena C. Ignacio, M.D., John H.C. Kim, M.D., and Kay Kaita, R.N.

Book Reviews 307

Continuing Medical Education 305

Editorials 302

Hawaii Academy of Family Physicians' Newsletter 310

HMA Council Meeting 304

HMA Newsletter 301

Index to Volume 34 317

In Memoriam 312

Letters to the Editor 287

New Members 303

alifor ia 94143

LIBRARY
U.C. SAN FRANCISCO
NOV 10 1976

Both often



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium®
(diazepam) Ⓡ IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

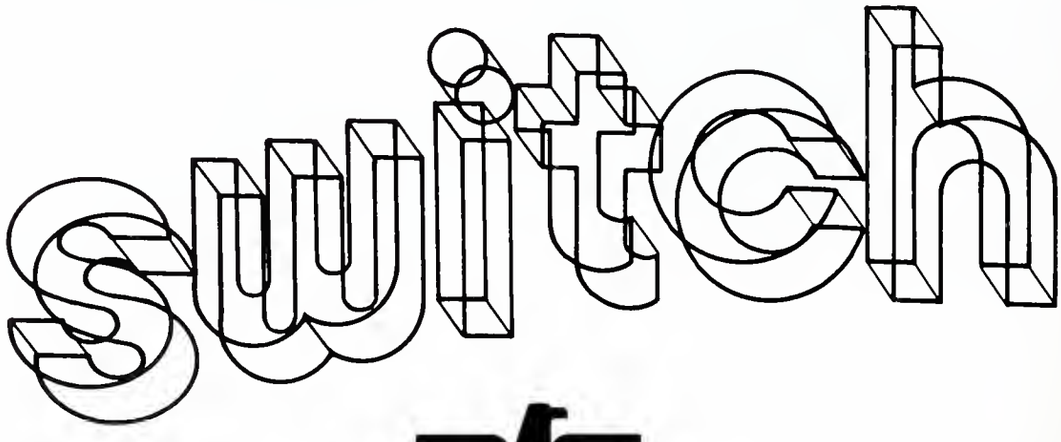
ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

the big mort-gage

home loans to $200,000

Money for the big mortgage isn't always available. But right now American Security Bank has it. The terms are competitive. The service is fast. If you need up to $200,000 to buy that dream home, refinance an agreement of sale or existing first mortgage, call us. Now.



to

American Security Bank

Mortgage Division • 525-7888

EQUAL HOUSING LENDER

Hawaii Medical Journal

Published Monthly by the
HAWAII MEDICAL ASSOCIATION
(Incorporated in 1856 under the Monarchy)
320 Ward Avenue, Honolulu, Hawaii 96814

EDITORS

Editor, HARRY L. ARNOLD, JR., M.D.
News Editor, HENRY N. YOKOYAMA, M.D.
Assistant Editor, DORIS R. JASINSKI, M.D., M.P.H.
Contributing Editor, ROBERT H. MOSER, M.D.
Contributing Editor, J.I. FREDERICK REPPUN, M.D.
Book Review Editor, WINFRED Y. LEE, M.D.
Executive Editor, PAUL STEWARD

OFFICERS

President, WILLIAM W.L. DANG, M.D.
President-Elect, CALVIN C.J. SIA, M.D.
Past President, WINFRED Y. LEE, M.D.
Secretary, R. VARIAN SLOAN, M.D.
Treasurer, GROVER H. BATTEN, M.D.

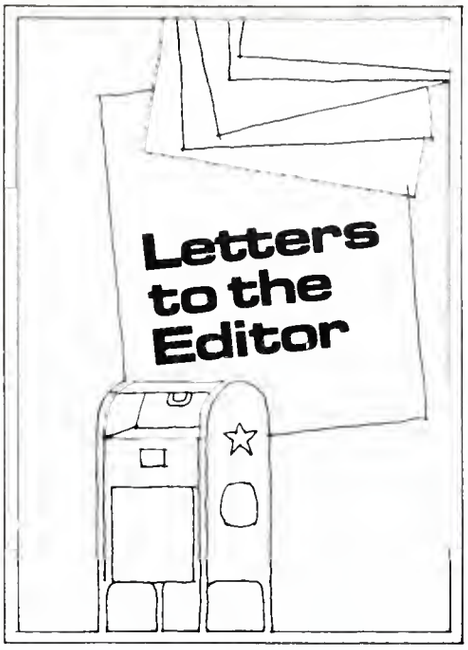
County Presidents

Hawaii, KENNETH HUGHES, M.D.
Honolulu, DOUGLAS B. BELL, II, M.D.
Kauai RIEAZI REMITIO, M.D.
Maui, CLIFFORD MORAN, M.D.
Delegate to AMA, GEORGE H. MILLS, M.D.
Alternate Delegate to AMA,
HERBERT Y.H. CHINN, M.D.

Advertising Representatives
National:
HAWAII MEDICAL ASSOCIATION
320 WARD AVENUE
Honolulu, Hawaii 96814
Phone (808)536-7702
Honolulu:
LILITH JURRY, Phone 946-0053

THE JOURNAL may not be held responsible for opinions expressed in papers, discussions, communications, or advertisements. The advertising policy of the HAWAII MEDICAL JOURNAL is governed by the rules of the Council on Drugs of the American Medical Association. The right is reserved to reject material submitted for editorial or advertising columns. All material for publication must be in the hands of the editor on or before the 10th day of the month preceding publication date. Reprints of original articles will be supplied at actual cost. A reasonable number of illustrations accompanying an article will be accepted for printing. The right is reserved to ask the author to bear cost of these when it is found necessary to do so.

Copyright 1976 by the Hawaii Medical Association, Honolulu, Hawaii. 2nd class postage paid at Honolulu, Hawaii. Office of Publication: 320 Ward Avenue, Honolulu, Hawaii 96814.



TO: Members of the Hawaii Medical Association
FROM: Alan Pavel, M.D.
RE: Professional Liability Insurance

Each of you has recently received a letter from Dr. Claude Caver, proposing what Doctor Caver regards as an alternate solution to the malpractice insurance problem.

I respect Doctor Caver's right to make this proposal and am in sympathy with a few of the points he makes. When considering **his** ideas, (and the ones that I propose following), I hope you will maintain a proper perspective with regard to the various aspects of the malpractice problem and not allow emotionalism to cloud your good judgment.

Doctor Caver's Proposed Solution to the Malpractice Problem

The creation of the Hawaii Physicians' Protective Association to defend against malpractice actions is really like setting up a small "insurance company" which will defend its "policy-holders," although they will have to pay any judgment rendered by a court against them themselves. This "partial insurance company" will of necessity have to have some rules and regulations, and it will have to be supported by yearly premiums and in the end will be an insurance company offering partial protection. This portion of Doctor Caver's proposal has some merit although I think a physicians' owned and operated **complete** insurance company probably makes more sense.

A second part of Doctor Caver's proposal seems less rational to me. The idea that a physician without insurance is somehow "protected" against a malpractice action makes little sense to me. A grieved and angry patient, coupled with an aggressive plaintiff's attorney, will not consider a doctor's non-insurance status as protection for the doctor. Even if the physician can find a way to "hide" some of his assets, his accounts receivable

continued page 308

aggravating



...allergic dermatoses

with strong emotional overlay

Atarax®

(hydroxyzine hydrochloride)

TABLETS: 10 mg, 25 mg, and 50 mg

- rapid antianxiety action
- demonstrated antihistaminic activity

Contraindications: Hypersensitivity to hydroxyzine. Hydroxyzine, when administered to the pregnant mouse, rat, and rabbit, induced fetal abnormalities in the rat at doses substantially above the human therapeutic range. Clinical data in human beings are inadequate to establish safety in early pregnancy. Until such data are available, hydroxyzine is contraindicated in early pregnancy.

Precautions: Hydroxyzine may potentiate the action of central nervous system depressants such as meperidine and barbiturates. In conjunctive use, dosage for these drugs should be reduced. Because drowsiness may occur, patients should be cautioned against driving a car or operating dangerous machinery.

Adverse Reactions: Drowsiness may occur; if so, it is usually transitory and may disappear in a few days of continued therapy or upon dosage reduction. Dryness of the mouth may occur with higher doses. Involuntary motor activity, including rare instances of tremor and convulsions, has been reported, usually with higher than recommended dosage.

Supply: Tablets, containing 10 mg, 25 mg, or 50 mg hydroxyzine hydrochloride, 100's and 500's; Tablets, containing 100 mg, 100's; Syrup, containing 10 mg per teaspoonful (5 ml) and ethyl alcohol 0.5% v/v, pint bottles.

Before prescribing or administering, see package circular.

ROERIG Pfizer

A division of Pfizer Pharmaceuticals
New York, New York 10017

We're the only lab in the islands affiliated with Bio-Science.

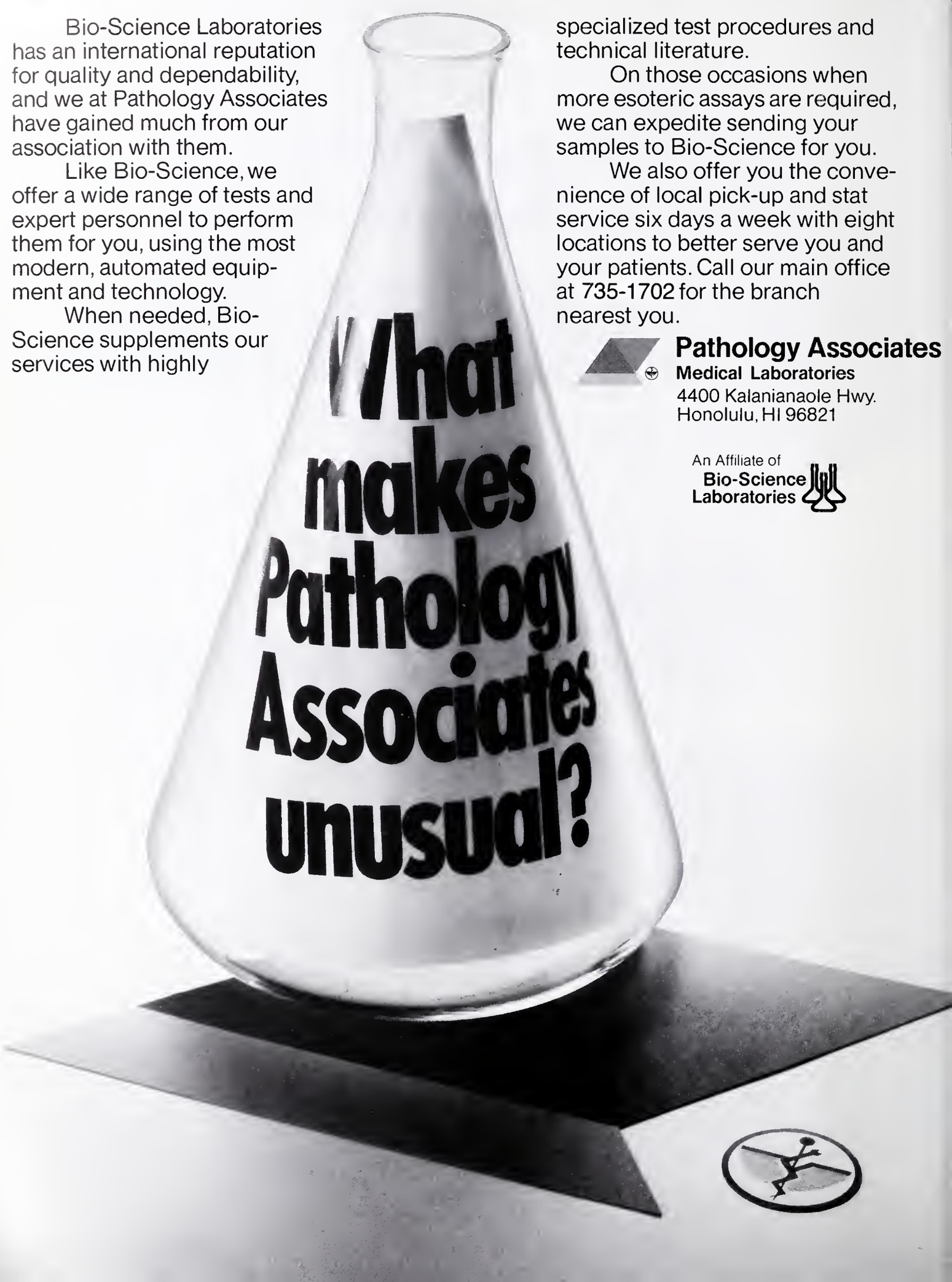
Bio-Science Laboratories has an international reputation for quality and dependability, and we at Pathology Associates have gained much from our association with them.

Like Bio-Science, we offer a wide range of tests and expert personnel to perform them for you, using the most modern, automated equipment and technology.

When needed, Bio-Science supplements our services with highly specialized test procedures and technical literature.

On those occasions when more esoteric assays are required, we can expedite sending your samples to Bio-Science for you.

We also offer you the convenience of local pick-up and stat service six days a week with eight locations to better serve you and your patients. Call our main office at 735-1702 for the branch nearest you.



Pathology Associates
Medical Laboratories
4400 Kalanianaole Hwy.
Honolulu, HI 96821

An Affiliate of
Bio-Science Laboratories

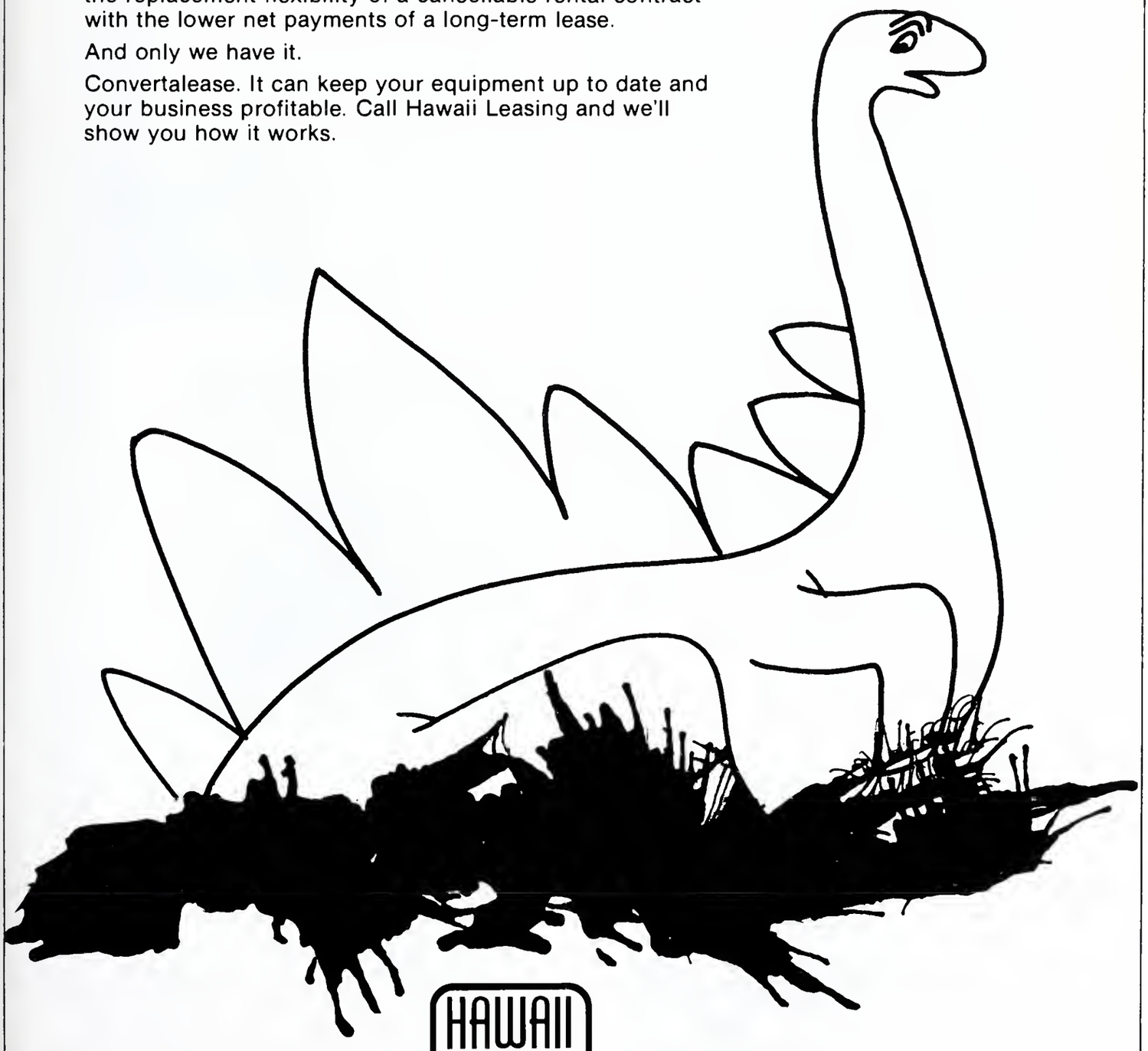
Obsolescence
...now it's obsolete

Equipment obsolescence and wear reduce efficiency and profit.

So it's important to replace equipment in time. But if you own equipment, you may not have recovered your investment through depreciation yet. And face it, we all tend to use something till it quits. Our answer is something that combines the replacement flexibility of a cancellable rental contract with the lower net payments of a long-term lease.

And only we have it.

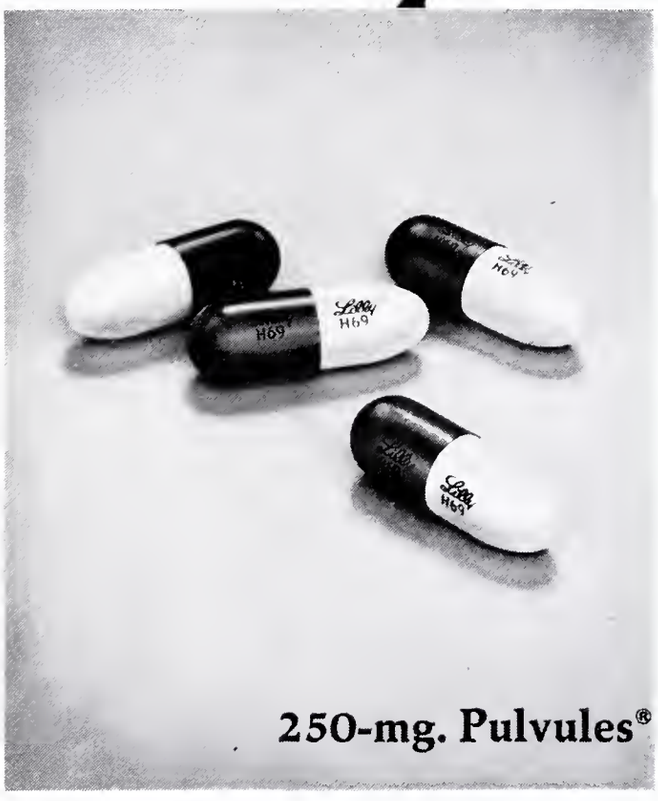
Convertalease. It can keep your equipment up to date and your business profitable. Call Hawaii Leasing and we'll show you how it works.

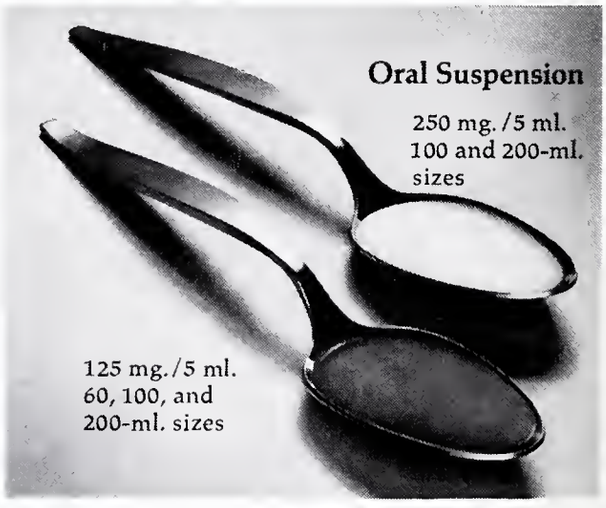


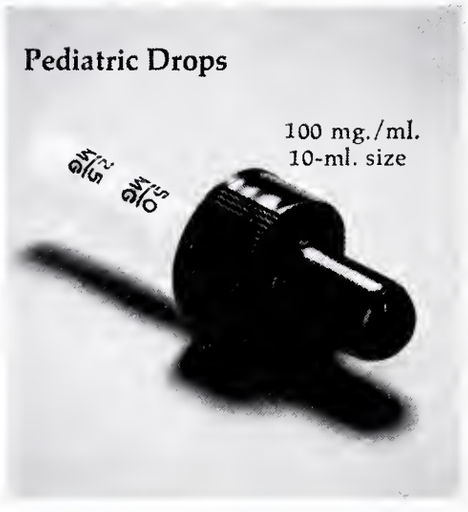
Today's answer. HAWAII MEDICAL LEASING 700 Bishop St., Suite 902 • Honolulu, Hawaii 96813 • 546-2949

An activity of Amfac *Financial*

easy to take







Keflex®
cephalexin

Lilly

Additional information available to the profession on request.
Eli Lilly and Company
Indianapolis, Indiana 46206

500738

Cancer Mortality Among Japanese in Hawaii

Comparison of Observed and Expected Rates Based on Prefecture-of-Origin in Japan

ABRAHAM NOMURA, M.D. *and* TOMIO HIROHATA, M.D., *Honolulu*

• *Summary standardized mortality ratios, specific for site and sex, and based on the Japanese prefectures from which the majority of Hawaii Japanese originated, were computed, with the Japan national cancer mortality rates as the standard. It was observed that the mortality ratios of both sexes in Hawaii for stomach cancer were lower than the Japan national rates, while the ratios for uterine cancer, esophageal cancer for males, and cancer of buccal cavity and pharynx for males and females were higher. The prefectural-based mortality ratios were then utilized to determine the expected cancer rates among the Japanese in Hawaii. These rates were compared with observed cancer mortality rates among Hawaii Japanese, and it was noted that the Hawaii Japanese have experienced a marked increase in mortality from cancer of the large intestine, lung, breast, and pancreas, as well as a decrease of cancer of the stomach and uterus.*

It has often been cited that Hawaii Japanese have different cancer rates from Japanese in Japan. This impression has been based on generalized data such as: 1) cancer mortality rates of U.S. Japanese and the total population of Japan, presented by Haenszel and Kurihara;[1] and 2) cancer incidence rates of the Japanese residents of Hawaii and of Miyagi and Okayama prefectures, published in "Cancer in Five Continents" by Doll *et al.*[2] Because cancer rates have as much as a three-fold difference by prefectures in Japan, comparisons between Hawaii and Japan would be more meaningful if they were primarily limited to the seven prefectures from which the vast majority of Hawaii Japanese originated. Such comparisons could better determine if genetic or environmental factors played a predominant role in oncogenesis.

Reprint requests to Dr. T. Hirohata, Professor, School of Public Health, University of Hawaii, 1960 East-West Road, Biomedical Science Building D-102, Honolulu, Hawaii 96822

Supported partially by NCI Contract NO1-CP-53511 and Grant NO 1 PO1 CA 15655-01

Accepted for publication Oct. 14, 1975.

In this investigation, the assumption was made that cancer mortality rates of Hawaii Japanese are the same as those in Japanese prefectures from which these migrant Japanese originated. On this basis, the rates of the prefectures-of-origin of Hawaii Japanese were utilized in computing their expected cancer mortality rates. The expected rates were then compared with the observed mortality rates in Hawaii and the findings were evaluated in relationship to other studies which did not take into account prefecture-of-origin.

Methods

Two sources of information were used to derive the expected cancer mortality rates of Hawaii Japanese based on their prefecture-of-origin: 1) The Honolulu Heart Program which recorded the frequency distribution of Hawaii Japanese men by prefecture-of-origin[3] 2) Segi's compendium of cancer[4] which included the 1950-59 age-adjusted standardized mortality ratios (SMR) of all prefectures of Japan. SMR by sex and cancer site were weighted by the estimated frequency distribution of the Hawaii Japanese by prefecture-of-origin. After weighting each prefectural SMR for a specific cancer site, these were totaled to derive a summary SMR, which was multiplied by the appropriate 1960 age-adjusted Japan mortality rate to derive the expected mortality of Hawaii Japanese. An example of these computations for stomach cancer in males is given in Table 1.

The observed age-adjusted mortality rates among the Hawaii Japanese for 1960 were computed from data of the Department of Health, State of Hawaii. The average annual deaths from 1958-62 were divided by the 1960 Census population of Hawaii. The WHO 1950 world standard population utilized by Segi[4] was the reference population for calculating the age-adjusted rates.

TABLE 1.—*Computation of Expected Stomach Cancer Mortality Rate per 100,000 Hawaii Japanese Males for 1960, Based on their Prefecture-of-Origin*

ORIGIN	ESTIMATED FREQUENCY DISTRIBUTION BY PREFECTURE-OF-ORIGIN*		SMR**		WEIGHTED SMR
Hiroshima	.25	X	0.89	=	.223
Yamaguchi	.23	X	0.90	=	.207
Okinawa***	.14	X	0.49	=	.069
Kumamoto	.14	X	0.69	=	.097
Fukuoka	.06	X	1.05	=	.063
Niigata	.05	X	1.25	=	.063
Fukushima	.04	X	1.03	=	.041
Others	.09	X	1.00	=	.090
TOTAL	1.00				0.853

Summary SMR (0.85) X 1960 age-adjusted Japan mortality rate (71.6/100,000) = Expected Mortality Rate (60.9/100,000/yr.)

*from ref. 3
**from ref. 4
***from ref. 5

TABLE 2.—*Site-specific Summary SMR Relative to 1960 Japan National Cancer Rates*

CANCER SITE (ISC, 7TH REV.)		MALE	FEMALE
All malignant neoplasms	(140-205)	0.96	0.99
Buccal cavity and pharynx	(140-148)	1.34	1.20
Esophagus	(150)	1.22	1.02
Stomach	(151)	0.85	0.87
Large Intestine	(153)	1.05	1.01
Rectum	(154)	1.01	0.99
Liver & biliary passage	(155-156)	1.04	0.94
Pancreas	(157)	0.94	0.92
Lung, bronchus & trachea	(162-163)	1.09	1.02
Breast	(170)	—	0.92
Uterus	(171-174)	—	1.15
Leukemia	(204)	1.07	1.08

Results and Discussion

Table 2 shows site-specific summary SMR, relative to 1960 Japan cancer rates. As seen in Table 1, these ratios were weighted by the estimated frequency distribution of Hawaii Japanese by each prefecture-of-origin. It is noteworthy that the SMR for stomach cancer were only 85% for males and 87% for females, which indicated that the occurrence of stomach cancer was less common in prefectures from which Hawaii Japanese originated. In contrast to cancer of the stomach, cancer of buccal cavity and pharynx showed much higher ratios, 1.34 for males and 1.20 for females. The SMR of esophageal cancer for males and uterine cancer were also high, 1.22 and 1.15, respectively. Other sites of cancer selected for analysis showed SMR varying within the range of plus or minus 10% of the national average.

The observed and expected cancer mortality rates of Hawaii Japanese, based on prefecture-of-origin, are given in Table 3. The Japanese men had a higher and the women a lower cancer mortality rate than expected. The rise in deaths among men was primarily due to cancers of the following sites: lung, large intestine and pancreas. The magnitude of the differences was sufficient to offset the large decrease in mortality attributable to gastric cancer in men. For women, the decrease in deaths was primarily due to the fall in cancer mortality of the stomach and uterus. This was of such magnitude that it nullified the increase in deaths from cancer of the breast, lung, large intestine, and pancreas.

For comparative purposes, Table 4 lists data from Haenszel and Kurihara[1] who utilized U.S. Mortality data for Japanese in the United States (Continental U.S. and Hawaii) and Segi's 1964 compendium[6] for cancer mortality rates of Japan. Standardized mortality ratios of U.S. Japanese relative to Japan have been age-adjusted for males and females, respectively, in Table 4. Table 5 is derived from "Cancer in Five Continents" by Doll *et al.*[2] It compares incidence rates of Japanese in Hawaii with Miyagi and Okayama prefectures.

Stomach. The magnitude and consistency of the findings for stomach cancer in Tables 3 to 5 strongly suggest that the decrease in gastric cancer risk in Hawaii Japanese is genuine. Furthermore, stomach cancer mortality in Japan has remained relatively constant for many years,[1] while there has been a marked decline in gastric cancer mortality in the U.S. and many other

TABLE 3.—*Observed and Expected Age-adjusted Mortality Rate Per 100,000 Hawaii Japanese by Sex and Primary Site, 1960*

CANCER SITE	ISC 7TH REVISION	AGE-ADJUSTED MORTALITY RATE/100,000					
		MALE			FEMALE		
		OBSERVED	EXPECTED	O/E	OBSERVED	EXPECTED	O/E
All malignant neoplasms	(140-205)	153.3	132.0	1.16	81.0	96.7	0.84
Buccal cavity & pharynx	(140-148)	2.7	1.7	1.59	1.4	0.7	2.00
Esophagus	(150)	8.8	8.4	1.05	0.8	2.3	0.35
Stomach	(151)	42.6	60.9	0.70	20.5	32.4	0.63
Large intestines	(153)	9.9	2.6	3.81	4.9	2.6	1.88
Rectum	(154)	5.5	4.1	1.34	2.7	3.5	0.77
Liver & biliary passage	(155-156)	11.5	16.1	0.71	5.4	9.1	0.59
Pancreas	(157)	7.7	2.8	2.75	5.4	1.7	3.18
Lung, bronchus & trachea	(162-163)	25.0	10.8	2.31	6.7	3.7	1.81
Breast	(170)	—	—	—	5.3	3.5	1.51
Uterus	(171-174)	—	—	—	8.1	18.5	0.44
Leukemia	(204)	5.8	3.5	1.66	3.4	2.7	1.26

TABLE 4.—*Cancer Mortality Ratios of U.S. Japanese Standardized to Japan, by Sex and Primary Site, 1959-62*

CANCER SITE	ISC 7TH REVISION	MALES	FEMALES
All sites	(140-205)	1.11	0.80
Buccal cavity & pharynx	(140-148)	1.43	1.07
Esophagus	(150)	1.13	0.36
Stomach	(151)	0.62	0.52
Intestines	(152-153)	3.46	2.11
Rectum	(154)	1.34	0.69
Liver	(155.0)	1.50	0.76
Biliary passages	(155.1, 155.8)	2.32	2.35
Pancreas	(157)	3.64	2.56
Lung & bronchus	(162, 163)	2.66	1.70
Breast	(170)	—	1.48
Cervix uteri	(171)	—	0.39
Other uterus	(172-174)	—	1.94
Leukemia & Aleukemia	(204)	1.80	1.17

TABLE 5.—*Annual Age-adjusted Cancer Incidence Rate per 100,000 Japanese in Hawaii and Japan, by Sex and Primary Site*

CANCER SITE	ISC 7TH REVISION	MALES			FEMALES		
		HAWAII	MIYAGI	OKAYAMA	HAWAII	MIYAGI	OKAYAMA
All sites	(140-205)	207.6	196.0	189.3	160.8	142.8	145.4
Esophagus	(150)	6.8	14.5	4.1	0.6	4.9	2.2
Stomach	(151)	47.6	95.3	93.9	26.9	44.7	45.7
Large Intestine	(153)	20.7	4.1	4.6	15.3	4.0	4.6
Rectum	(154)	11.7	4.8	6.7	9.3	5.0	4.5
Liver	(155.0)	6.7	1.3	0.3	1.1	0.8	0.4
Gall Bladder	(155.1)	4.7	5.4	2.3	6.4	5.3	2.2
Pancreas	(157)	8.0	6.7	4.0	4.9	3.8	2.7
Lung & Bronchus	(162, 163)	26.3	15.6	15.3	7.6	6.0	5.2
Breast	(170)	—	—	—	23.0	11.0	12.4

countries over the past fifty years.[7] These observations indicate that environmental factors may play a major role in the etiology of stomach cancer.

Nitrosamines, formed by the action of nitrites on secondary or tertiary amines which can be in the diet, are highly suspect as one of the causative agents of gastric cancer.[8] It has been demonstrated that this formation of nitrosamines can occur in the presence of gastric juice.[9] It may also be possible that nitrosation is promoted by intestinal bacteria when the pH of the stomach is elevated.[10] Haenszel *et al.*[11] recently observed that in Hawaii, the consumption of dried/salted fish and pickled vegetables was linked to the occurrence of stomach cancer. Dried fish, as well as other foods, has high concentration of secondary amines. Nitrite and nitrate contents in pickled

vegetables are now being extensively investigated in Japan. Pickled foods are consumed much more in Japan than in Hawaii and such foods may be associated with the higher gastric cancer rate in Japan.

In all, more evidence is needed to substantiate a causal association of nitrosamines with stomach cancer. In order to do this, studies of the chemistry of suspect food items, the development and refinement of animal models of gastric cancer, and prospective studies of dietary exposures should be emphasized.

Intestines and Rectum. Similar to U.S. migrants from Poland[12] and Norway,[13] Hawaii Japanese appear to have increased their risk for colon cancer, as shown in Tables 3 to 5. The rise in mortality rates among men seems greater than in women, suggesting that there is a sex differential in exposure to environmental factors responsible for the increase in colon cancer rates.

In contrast to the colon, the pattern of differences in Hawaii and Japan rates for rectal cancer was not uniform in Tables 3 to 5. There was an increase of rates among Japanese men in Hawaii, but the women in Hawaii manifested a lower death rate and a higher incidence rate for rectal cancer. Further investigation is needed to determine if rectal cancer is increasing in frequency among Japanese women in Hawaii.

As with stomach cancer, it is generally felt that environmental factors play a major role in the development of large bowel cancer.[14] Available evidence suggests that this factor is dietary in nature and is likely to be related to dietary fat.[15] Work in metabolic epidemiology has suggested that diet influences bacterial flora and bile metabolites in feces.[16] Some investigators[16,17] have demonstrated that high risk populations appear to have higher levels of anaerobic bacteria, degraded bile acids and metabolized neutral steroids than people in low risk areas. It is important to see if identification and quantitation of bacterial flora and bile metabolites in stools of Japanese in Hawaii and in Japan will confirm these findings and point the direction to be taken for future research in colo-rectal cancer.

Pancreas. Although the data suggest that cancer of the pancreas is more common among Japanese in Hawaii than in Japan, this particular cancer is difficult to diagnose. Consequently, less confidence can be placed in the given rates. Furthermore, in a study of the accuracy of death certification in Japan, it was found that some pancreatic cancers identified on autopsy were mis-diagnosed as cancer of the stomach on the death certificate.[18] At the same time, none of the necropsy-proven stomach cancers were listed as pancreatic cancer on the death certificate. These findings suggest that there may be some under-reporting of the occurrence of pancreatic cancer in Japan. Whether it is of sufficient magnitude to nullify the supposed differences between Japan and Hawaii is a subject for future clarification.

Little is known about possible causative factors related to cancer of the pancreas. Cigarette smoking, chronic pancreatitis and diabetes have been suspect as precursor factors, but the data need further confirmation.[19]

Lung, Bronchus and Trachea. The rise in occurrence of lung cancer is an impressive finding in Hawaii Japanese. We are now investigating whether or not differences in lung cancer rates between Japanese in Hawaii and in Japan is attributable to possible differences in cigarette smoking.

Breast. Data from Table 3 suggest there is some increase in the occurrence of breast cancer in Japanese women in Hawaii. This is supported by the findings of Haenszel and Kurihara as well as Doll *et al.* More recent data from the Hawaii Tumor Registry seem to confirm the impression that Japanese rates in Hawaii are approaching the rates of Caucasians who are at high risk for breast cancer.[20]

It has been observed that women who develop breast cancer have the following characteristics: an earlier menarche,[21] later menopause,[22] a higher socio-economic status,[23] a large body frame,[24] and later age at first term pregnancy.[25] The latter characteristic of pregnancy accounts for only a small fraction of the well-known international differences in breast cancer incidence rates. MacMahon and co-investigators have observed that women in countries where rates are high have a lower urinary estriol proportion—estriol/(estrone + estradiol + estriol)—than women in countries where rates are low.[26] Japanese women in Hawaii are intermediate in both risk for breast cancer and the estriol proportion.[27] Although this finding clearly suggests that a low urinary estriol proportion, especially among young women, is a correlate of subsequent breast cancer risk, it is yet to be confirmed by other researchers.

Investigators suspect that dietary factors play a major role in explaining the observed international differences in cancer of the mammary gland. Indirect studies which compare breast cancer mortality rates with nutrient consumption in different countries, suggest that fat and protein intake is related to breast cancer.[28] Hill and co-workers[29] have hypothesized that gut bacteria are able to produce estrogens from biliary steroids which are excreted in greater quantities by women on a high fat diet. Recent data from the Japan-Hawaii Cancer Study suggest that women in Hawaii have more subcutaneous fat in their breasts as well as more apocrine metaplasia (a possible precursor of breast cancer) than women in Japan.[30]

Comment

A major problem in international comparisons of mortality rates centers around the comparability of medical and death certification practices between countries. Although this issue cannot be resolved in this investigation, indirect evidence is available which suggests that reporting and certification practices in Hawaii and Japan should be fairly comparable. First, the Atomic Bomb Casualty Commission (ABCC) necropsy studies in Nagasaki and Hiroshima did not indicate that descriptive data of vital statistics in Japan should be questioned.[17] Although disagreements between individual certifications and autopsy findings did exist, the differences tended to balance out in overall analysis. There was a suggestion that stomach and lung cancer were undercertified in Japan. If so, this would underestimate the downward displacement of stomach cancer among Hawaii Japanese and overestimate the upward displacement of lung cancer. Secondly, the consistent pattern of data on cancer incidence and mortality derived from different sources as shown in this study, suggest that changes observed in cancer occurrence among Hawaii Japanese are bona fide.

REFERENCES

1. Haenszel W, Kurihara M: Studies of Japanese migrants; 1. Mortality from cancer and other diseases among Japanese in the United States. *J Natl Cancer Inst* 40:43-68, 1968.
2. Doll, R: International Union Against Cancer, Cancer Incidence in Five Continents, Vol. 2, Springer-Verlag, Berlin, 1970.
3. Kagan A, Harris BR, Winkelstein W Jr, et al: Epidemiologic studies of coronary heart disease and stroke in Japanese men living in Japan, Hawaii and California: demographic, physical, dietary and biochemical characteristics. *J Chronic Dis* 27:345-364, 1974.
4. Segi M, Kurihara M, Matsuyama T: Cancer Mortality in Japan (1899-1962), Dept. of Public Health, Tohoku Univ. School of Medicine, Sendai, Japan, 1965.
5. Okinawa Igakkai, et al: Okinawaken ni okeru Akuseishinseibutsu no Rikan narabini Shibo no Zittai ni Kansuru Kenkyu. Nihon Ishikai Zasshi 66:831-852, 1971.
6. Segi M: Cancer mortality for selected sites in 24 countries, No. 3 (1960-61): Department of Puhlic Health, Tohoku University School of Medicine, Sendai, Japan, 1964.
7. Haenszel W: Variation in incidence of and mortality from stomach cancer, with particular reference to the United States. *J Natl Cancer Inst* 2:213-262, 1958.
8. Hill MJ, Hawksworth G, Tattersall G: Bacteria, nitrosamines and stomach cancer. *Br J Cancer*
9. Lijinsky W, Epstein SS: Nitrosamines as environmental carcinogens. *Nature* 225:21-23, 1970.
10. Wolff IA, Wasserman AE: Nitrates, nitrites and nitrosamines. *Science* 177:15-19, 1972.
11. Haenszel W, Kurihara M, Segi M et al: Stomach cancer among Japanese in Hawaii. *J Natl Cancer Inst* 49:969-988, 1972.
12. Staszewski J, Haenszel W: Cancer mortality among the Polish-born in the United States. *J Natl Cancer Inst* 35:291-297, 1965.
13. Haenszel W: Cancer mortality among the foreign-born in the United States. *J Natl Cancer Inst* 26:37-132, 1961.
14. Wynder EL, Shigematsu T: Environmental factors of cancer of the colon and rectum. *Cancer* 20:1520-1561, 1967.
15. Wynder EL, Reddy BS: Dietary fat and colon cancer. *J Natl Cancer Inst* 54:7-10, 1975.
16. Hill MJ, Drasar BS, Aries V et al: Bacteria and etiology of cancer of large bowel. Lancet 1:95-100, 1971.
17. Wynder EL, Reddy BS: Metabolic epidemiology of colorectal cancer. *Cancer* 34:801-806, 1974.
18. Jablon S, Angevine DM, Matsumoto YS et al: On the significance of cause of death as recorded on death certificates in Hiroshima and Nagasaki, Japan. *Natl Cancer Inst Monogr* 19:445-465, 1966.
19. Levin DL, Connelly RR: Cancer of the pancreas. *Cancer* 31:1231-1236, 1973.
20. Hawaii Tumor Registry. Personal communication.
21. Yuasa S, MacMahon B: Lactation and reproductive history of breast cancer patients in Tokyo, Japan. Bull WHO 42:195-204, 1970.
22. Shapiro S, Strax P, Venet P: Periodic breast cancer screening in reducing mortality from breast cancer. JAMA 215:1777-1785, 1971.
23. Graham S, Levin M, Lilienfeld AM: The socioeconomic distribution of cancer of various sites in Buffalo, New York, 1948-52. *Cancer* 13:180-191, 1960.
24. DeWaard F, Baanders-van Halewijn EA: A prospective study in general practice on breast cancer risk in postmenopausal women. *Intl J Cancer* 14:153-160, 1974.
25. MacMahon B, Cole P, Lin TM, et al: Age at first birth and breast cancer risk. Bull WHO 43:209-221, 1970.
26. MacMahon B, Cole P, Brown JB et al: Urine estrogen profiles of Asian and North American women. *Int J Cancer* 14:161-167, 1974.
27. Dickinson LE, MacMahon B, Cole P et al: Estrogen profiles of Oriental and Caucasian women in Hawaii. *N Eng J Med* 291:1211-1213, 1974.
28. Drasar BS, Irving D: Environmental factors and cancer of the colon and breast. *Br J Cancer* 27:167-172, 1973.
29. Hill MJ, Goddard P, Williams REO: Gut bacteria and etiology of cancer of the breast. Lancet 2:472-473, 1971.
30. Nomura A, Stemmermann GM, Rhoads GG et al: The Japan-Hawaii Cancer Study: A progress report. *HMJ* 34:309-316, 1975.

Is the diagnosis ALCOHOLISM?

Time proven alcoholism treatment — formerly available only at Mainland centers — now offered at Post Hospital Recovery Unit, Hilo Care Center.

- A basic, 28-day in-patient program of motivational counseling
- Therapists carefully selected and themselves recovered alcoholics
- Hawaii licensed professional consulting staff in psychiatry, psychology and family medicine
- Privacy, seclusion, total confidentiality in modern facility, beautiful setting

Direct inquiries to:
Marilee Fletcher, Associate Director,
Post Hospital Recovery Unit,
HILO CARE CENTER
944 West Kawailani Street
Hilo, Hawaii 96720 Phone (Hilo) 959-9151

Multidisciplinary Team Approach to Patient Education in Hypertension

AZUCENA C. IGNACIO, M.D., JOHN H.C. KIM, M.D., *and* KAY KAITA R.N., *Honolulu*

● *In our society people are no longer simply onlookers and casual bystanders, but are increasing their expectations of institutions. The control of a health care delivery system, specifically, mandates the awareness of the people. More questions as to the quality of health delivery are going to be made. Consumers in prepaid medical care programs have already begun this scrutiny.*

For better health delivery, the group hypertensive workshop was begun at Kaiser Foundation Hospital, Honolulu. The purpose of this paper is to introduce the methods used. Evaluation of the participants and appraisal of the techniques are described in part.

Materials and Methods

This study deals with 60 patients, all of whom were hypertensives and under medication. All were referred by their attending physicians, who had seen and treated them for not less than one year previously. Age and sex distributions are shown in Table 1.

Examinations to determine how much the patients knew about their disease were given before and after the course. The examination results are briefly shown in Table 3.

The workshops were divided into four sessions of two hours each, the first hour a lecture and group discussion, and the second hour the teaching of measurement of blood pressure, pulse, temperature and weight. Sessions were conducted by the hypertensive clinic staff consisting of physician-in-charge, resident physician, nurse, dietitian, and pharmacist.

Department of Medicine,
Kaiser Foundation Hospital,
Honolulu, Hawaii.

Accepted for publication October 1, 1975

After the fourth session, participants were asked to return one month later for follow-up in the hypertensive clinic. Evaluation was made of their ability to measure blood pressure, temperature, pulse, weight and to describe their symptoms. Some follow-up parameters in status of patients are shown in Table 4.

TABLE 1.—*Age and sex distribution of participants*

AGE	PARTICIPANTS
30-35	5
35-40	3
40-45	12
45-50	21
50-55	5
55-60	9
60-65	2
65-above	3
TOTAL	60
SEX	DISTRIBUTION
Men	45
Women	15
TOTAL	60

TABLE 2.—*Occupations of Participants*

Housewife	2
Clerk	32
Supervisor	5
Insurance Agent	5
College Instructor	3
Professor	3
Salesman	3
Businessman (Self-employed)	6
Teacher (Elementary)	1
TOTAL	60

Results

The 60 participants in the study ranged in age from 33 to 69, with the mean age 51 years, and

TABLE 3.—*Questionnaire Results*

	BEFORE	AFTER
All Correct Answers	16	59
Some Incorrect Answers	44	1
TOTAL	60	60

TABLE 4.—*Follow-Up After the Course*

Weight	
a. Gain	None
b. Loss	57
Lowered Blood Pressure	55
Pulse Irregularity	1
Others	
a. Chest pains	2
b. Palpitation	1

the mode 48 years. Men predominate by a ratio of 3:1. Most participants had finished high school and were employed. Only two were housewives. The distribution of occupations are in Table 2.

Written examinations were given the participants before the course. Of the 60, 44 patients gave some wrong answers. Most mistakes were made in the areas of diet, medication effects and side effects, differentiation between stroke and heart attack, importance of the kidney in high blood pressure, and systolic and diastolic blood pressure significance. After the course the participants were able to attain perfect scores, with one exception.

No participant was able to take his own blood pressure at the start of the course. By the third session, every participant knew how to take his own blood pressure, weigh himself, take temperature and pulse.

After the course, the participants were asked to come back and make a self-evaluation. Weight loss had been possible for 57 of the 60 patients, while 55 had lowered blood pressures. However, two complained of chest pains, though their electrocardiograms were normal. One who complained that his heart was irregular was shown on EKG to have ectopic atrial rhythm. Another patient complained of palpitations while he was watching football. (Table 4)

Discussion

History: In 1972, the chief of the Department of Medicine at Kaiser Foundation Hospital initiated the nurse-operated hypertensive clinic, for follow-up of controlled hypertensives by a nurse practitioner in cooperation with the attending physician. Most patient education was done on an unplanned individual basis. It was therefore decided to consolidate efforts and form a team whose main function would be a total comprehensive care of the hypertensive patient.

Objectives: The purposes of this educational program are:

1. To develop in the hypertensive patient an awareness of the positive steps that should and could be taken to:
 a. prevent progression of the disease
 b. prevent serious complications
 c. prevent dependency in the event of such complications
2. To develop in the hypertensive patient a greater concern for personal health.
3. To provide the hypertensive with a working knowledge of what can be accomplished by self-help and under what conditions help should be sought from the health delivery system.

Definition: Patient education has been defined thus: the educational experiences planned for the patient by professional personnel as a component of his care, to be differentiated from those unplanned experiences for learning purposes in the hospital and from other organizational or environmental factors which influence his behavior. (Simmonds)

Ulrich has given a more specific definition: Patient education should consist of organized health educational experiences, planned by physician, professional health workers, paramedics, and the patient himself, to meet the patient's learning needs, interest, capabilities and knowledge, and offered as an integral part of the total health care.

Description of the program: The Kaiser Foundation Hospital is a 182 bed hospital. It serves Kaiser Health Plan members, numbering 100,000. Professional services in the hospital are provided by the Hawaii Permanente Medical Group of approximately 100 physicians. The hypertensive workshop was initiated in the outpatient services, which has approximately 250,000 annual patient visits. It first started in the main medical facility, but later encompassed the peripheral clinics.

All patients were referred by their attending physicians, who had been seeing and treating the patients until blood pressure was fairly well controlled. All patients sent to the clinic had had hypertensive work-ups and were considered to be in the essential hypertension category. The clinic staff consists of physician-in-charge, resident physician, nurse, dietitian, pharmacist, and at certain times medical social worker. Patients are followed in the hypertensive clinic and are sent back to their attending physicians at least once a year. If any complications arise while the patient is being followed in the clinic, the nurse can ask the help of the physician-in-charge or the resident physician.

Review of literature concerning patient education revealed that the most prevalent type of facility reporting was the general voluntary hospital of 150-180 beds. Programs commanding

the most attention in the literature fell into the following categories:

1. patient and family education about diabetes
2. prepartum education
3. patient and family education about tuberculosis
4. nutrition education
5. diet instruction
6. counselling for parents of handicapped children
7. education about cancer

Nowhere in the literature was there mention of a total comprehensive approach to patient education among hypertensive patients. Frequently, the focus was on media, such as pamphlets, booklets, television and other programmed instruction. Group teaching and self-help methods were minimally initiated in the self-help program of the hemodialysis units. Our program seems to be the first hypertensive workshop.

Whereas patient education programs are often staffed by volunteers, our program makes use of professional personnel. Desirable results derive from the multidisciplinary approach to patient education, namely:

1. Teaching plans are developed to suit the needs and abilities of the patients.
2. The educational period spreads across several days or weeks, thus permitting the instructors to repeat information as required. This also allows patients to ask questions on specific aspects which they did not understand.
3. It permits the patients to demonstrate their ability and capacity to learn and at the same time to practice the skills that they have mastered.
4. The attending physician of each patient becomes an active participant of the teaching process by initially authorizing the patient's instruction.
5. A carefully planned program assures uniformity of instruction.
6. The professional team responsible for the instruction of the patients promotes the cooperation of other personnel in the hospital.
7. Evaluation of patients' progress enables the team to ascertain if the teaching is successful.
8. Finally, the patient appreciates the extra attention and special concern shown him. (Ed. note: the "Hawthorne effect".)

The patient feels that he is a participant and not merely a recipient in the health care program.

Conclusions

Because of the need for better health care delivery to subscribers of such immense proportion as the members of Kaiser Health Plan, the hypertensive workshop was begun. In view of the necessity of disseminating information on a large scale and at once, the multidisciplinary team approach for teaching patients was conceived and appears the most logical and the most promising. With this method, team members of varying professional backgrounds bring their special skills and talents to bear upon the particular needs of the patients. At the same time, cooperation from the patient is achieved if the patient is given certain responsibilities for the attainment of his better health care. The more the patients are aware of their responsibilities to achieve better health care, the more they can cooperate to fullfill this need.

The multidisciplinary approach offers the most effective method of patient education. Instead of the patient/subscriber/consumer being a casual onlooker, he becomes the center of interest and an important ingredient to the success of better health endeavors.

This program not only provides instruction, but also is a vehicle to influence the patient toward understanding and attaining optimum health.

Acknowledgement

Supported in part by a grant from
Mr. and Mrs. Tony DiMauro

REFERENCES

1. A Model for Planning Patient Education: Report of the Committee on Educational Tasks in Chronic Illness Public Health Education Section, American Public Health Association, 1970.
2. Readings in Health Education: American Hospital Association, 1969.
3. Skinner, Mayhew: Health Education for Outpatients Public Health Reports Vol. 69, #11 November 1954.
4. Ulrich: The Hospital as a Center for Health, Health Education, 1972.
5. Strategies for Patient Education: Proceedings of Second Invitational Conference on Patient Education, 1969 American Hospital Association, 1972.
6. Hayakawa: A Proposal for a Patient Education Program Public Health Education Program, 1973.



H. Tom Thorson

Flu Vaccine has arrived and initial administration has been started with high risk population groups.

Nebraska joins AMA and North Carolina in suit against implementation of planning law—93-641.

American Hospital Association steps up battle against excessive government controls—increases dues by 17.1% to build a war chest to fight federal interference.

Health Manpower Bill approved with $2 billion voted over the next three years for medical education. AMA fought to eliminate excessive strings such as dictation of curriculum, regional allocations, federal service, and licensure. Medical schools will be required to produce more "primary care" physicians as one of the conditions to receive capitation aid, the schools must have in 1978, at least 35% of their filled first year positions in direct or affiliated residencies in primary care, defined as family medicine, general internal medicine, and general pediatrics. This percentage rises to 50% by 1980.

AMA supports crackdown on Medicaid fraud, recommending "time in jail" for those found guilty.

AMA plans a series of Young Physician Workshops for practice management to be held in February at AMA headquarters in Chicago.

AMA Clinical convention will be in Philadelphia starting December 4.

HMA Annual Meeting starts October 24 with registration. Scientific postgraduate courses start on Monday, October 25. House of Delegates meets on Wednesday, October 27 and on Friday, October 29. You are urged to pre-register.

Malpractice Update—it appears probable that by the time of the Annual Meeting initial steps will have been taken to buy time to get necessary amendments through the legislature. There are a number of major changes that need to be made.

Hawaii Tumor Registry has moved to the 320 Ward Building. The phone number is unchanged—521-0054.

Open House at new HMA offices at 320 Ward Avenue is scheduled for October 28 at 5:00 PM. All members are urged to visit the new quarters and familiarize themselves with the new offices.

Council Budget Meeting on October 1 approved for referral to the House of Delegates a budget in excess of $500,000. This is the first half-million budget in our history.

Practice Opportunity—Hawaii Mental Health Service in Hilo feels the need of a private practice psychiatrist to whom they can refer patients for treatment. Contact John C. Mebane, M.D., at Hilo Counseling Center, 37 Kekaulike St., Hilo, Hawaii 96720.

Medicare Audit problems crop up. Aetna reports they have a problem with statements for care-errors in computation, RVS codes, addresses, inadequate description of services, etc. HEW looks on these as a violation of integrity and Aetna has the job of explaining. They apparently have not had a warm reception by the physicians when they make their calls to straighten out the errors. It isn't the fault of the local office that HEW insists on using the 1964 California RVS. The local people are trying to help you. If you don't do it according to the book, HEW thinks you are cheating.

Election Notes—The primary election produced very few surprises and now the attention focuses on the general election. The makeup of the next legislature is extremely critical to the profession. Each physician should contact the candidates in his district and find out where they stand on amending Act 219, the malpractice bill. It isn't essential that you go into detail, because there are numerous amendments that need to be made, but if they do not agree that major amendments are necessary, vote for the one that

does agree to amend. Not only that, tell them so and also talk to your patients. One thing that candidates understand is the matter of **votes.** If you work at it, you have tremendous influence. **Join HAMPAC!!!!**

Register Now For The Annual Meeting—October 25-29, 1976.



. . . in our defense!

Senator Moss of Utah has done this nation a disservice.

The Senator's investigations of abuses in the delivery of Medicare and Medicaid and the attendant headlines, have unjustly hurt medicine's image. All the more so since the leading offenders were chiropractors rather than physicians.

Actually, less than 4% of all so-called abuses can be blamed on physicians, if the Senator's statistics are carefully scrutinized.

However, what needs rebutting and perhaps even a countercharge is the way in which the Senator gathered his data.

According to the newspapers, Senator Moss directly, as well as indirectly, through his staff of investigators, presented themselves as patients to various practicing doctors, clinics and ambulatory care facilities.

Everyone of us has had considerable experience with, and appreciates quite well, the problem posed by a patient who is either "worried well" as Dr. Garfield of Kaiser/Permanente once put it, or one who has vague symptoms and no signs.

Wasn't it one physician, who threw the Senator out of his office (or one of his henchmen) and said: "Hell, there's nothing wrong with you; get on out of here"? How many of us would have the temerity to say or do the same thing?

Much more likely, for most of us, is the instance of a patient who believes himself ill, or is truly ill, who has a pain or a symptom that cannot be corroborated by a sign. Is it because there are no signs? Is the sore throat not confirmed by any redness or dryness of the mucus membrane? Is the "pain" in the abdomen, and the abdomen is "soft, flat, non-tender, with normal peristalsis"?

Would any of you have the foolish unsubstantiated conviction that a sixty-year old overweight smoker with a complaint of chest pain should be sent out the door with just a reassuring pat on the shoulder?

In this day and age of distrust of the new and unfamiliar patient, of "defensive medicine" as a practice shadowed by the possibility of suits, who can blame the physician for "over-diagnosing," "overutilization," and "over treating"? He could be severely censured by society, much less by his peers, if that physician failed to put that patient through the mill.

Recently, a 19-year old, a previously healthy and athletic man, fainted in a super market. Later we discovered he had not eaten for some time. By the end of the case history, he had been rushed by ambulance to the hospital emergency room, an EKG taken, blood gases drawn and tested, an EEG done because the ER physician thought he looked pre-tictal, chemistries and lytes ordered, and he was finally hospitalized overnight "for observation." The young man's personal physician was called in late, ie, after the patient was well along the medical conveyor belt—so far along that the patient's M.D. dared not interrupt the process. Next morning the young man went home, having enjoyed the "Royal Hawaiian Hotel" suite with all the amenities, perfectly well!

If Senator Moss had actually fainted—and particularly in a supermarket, an example of a business house that is as afflicted with "liability consciousness" as we physicians are—he might well have expected and gotten, the same routine. If he had had an Adams-Stokes syndrome, anything less in the way of medical care would have sent him howling to the Press, claiming "under" utilization!

Someone involved in Senator Moss's investigation on the abuses in Medicare and Medicaid should sue him for fraud and misrepresentation!

We repeat: The patient who shows the least evidence to confirm a complaint, is the one most likely to be the most thoroughly studied, and even treated.

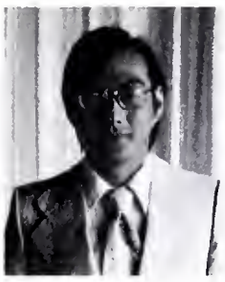
Especially is this likely in a milieu of lavish third party coverage, such as in government health insurance, where costs don't count, ie, don't hurt the patient.

As the American Academy of Family Physicians, succinctly put it, as a policy statement on the subject: "Abuses are inherent to the system."

J. I. F. R.



New Members



Dennis S. Murakami, M. D.

1481 South King Street,
Honolulu, Hawaii 96814

INTERNAL MEDICINE



Meredith Kwock Leong Pang, M. D.

1374 Nuuanu Avenue, Suite 202
Honolulu, Hawaii 96817

OTOLARYNGOLOGY



Avery M. Freed, M. D.

888 South King Street
Honolulu, Hawaii 96813

RADIOLOGY (Diagnostic)



Louis J. Polskin, M. D.

Tripler General Hospital
APO San Francisco, California 96438

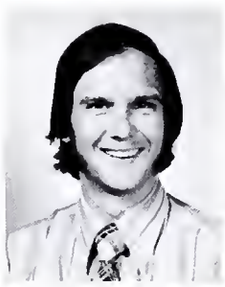
FAMILY PRACTICE



Bert N. Gilling, M. D.

1834 Nuuanu Avenue
Honolulu, Hawaii 96817

ANESTHESIOLOGY



Neal G. Sutherland, M.D.

Tripler Army Medical Center
P.O. Box 156
APO, San Francisco, California 96438

INTERNAL MEDICINE



Richard Kimura, M. D.

1833 North King Street
Honolulu, Hawaii 96819

ORTHOPEDICS



Elbert Tomai, M. D.

1024 Piikoi Street
Honolulu, Hawaii 96814

OBSTETRICS AND GYNECOLOGY



James T. Lambeth

144 Haili St.
Hilo, Hawaii 96720

RADIOLOGY



Dan Shoji Yoshioka, M. D.

1414 Alexander Street
Honolulu, Hawaii 96822

ANESTHESIOLOGY



CALL TO ORDER

The meeting was called to order by President William W. L. Dang. Also present were Drs. Calvin C. J. Sia, R. Varian Sloan, George H. Mills, Herbert Y. H. Chinn, Ann B. Catts, Albert C. K. Chun-Hoon, George Goto, John Kim, Rowlin Lichter, Carl Lum, Fred Reppun, Arnold Siemsen, Sakae Uehara, Douglas Bell II, Clifford Moran, Thatcher Magoun, and Kenneth Hughes plus Dr. Roy Kuboyama, Mrs. Lila Johnson from the Auxiliary, and Mr. V. Thomas Rice.

Medical Malpractice Insurance: Representatives from Argonaut Insurance Company appeared before the Council and announced that Argonaut's application for a rate increase of 82% was denied by the Hawaii Insurance Commissioner; however, approval for an increase of approximately 50% will probably be approved prior to September 1, 1976. It was also announced that effective September 1, 1976, Argonaut will no longer offer annual insurance policies but will change to a three-month policy program. The representatives presented several charts and diagrams illustrating the methodology used in determining insurance reserves, policy premiums, etc.

Dr. Chun-Hoon reported that the *ad hoc* Committee on Medical Malpractice had met prior to the Council meeting and had discussed the pending rate increases proposed by Argonaut. The *ad hoc* committee discussed at length the formation of a doctor's self-insurance company. The committee also recommends that HMA continue to work with attorneys to draft a compulsory voluntary arbitration agreement that could be used by those physicians who desire to enter into an arbitration agreement with their patients.

Attorney V. Thomas Rice reported that he and his staff are currently investigating the constitutionality of the insurance-for-licensure requirement. The American Medical Association has offered to assist the HMA should legal action become necessary.

ACTION:

It was voted to proceed with the initial phase of filing a suit and an appropriation of $5,000.00 was authorized. It was further voted that the HMA again pursue the idea of forming a self-insurance company and that the AMA be contacted and asked to provide any data they have on self-insured companies.

Mr. Won reported that he had recently visited the Medical Insurance Exchange Company in California which is a physician-owned company that has been in operation for one year. The MIEC is interested in having Hawaii physicians join their reciprocal company; however, the present insurance laws may not allow this.

MINUTES

The minutes of the May 28, 1976, meeting were approved as circulated.

SECRETARY

The report of the Secretary was reviewed and accepted.

REPORT OF THE TREASURER

The June 1976 financial statement was reviewed.

ACTION:

It was voted to approve the June 1976 financial statement subject to audit.

REPORT OF THE AUXILIARY

Mrs. Lila Johnson reported that there was a full complement of the Auxiliary at the AMA meeting in Dallas. The Hawaii Auxiliary received an award for the largest increase in AMA-ERF contributions. Mrs. Johnson also noted that the Auxiliary is helping with volunteers for the Swine Flu program.

COMMITTEES AND COMMISSIONS

A. Publications: At the May 28, 1976 meeting, the Council voted to publish an annual roster. Since that time, the Publications Committee has been in contact with Elson-Alexandre, the publishers of the 1975 Roster, who have offered a proposal to the HMA for printing an annual directory. The terms of the proposal were reviewed.

ACTION:

The Council voted to request the Publications Committee to pursue the publication of a Roster for 1977 and to present their recommendations to the House of Delegates in October 1976.

B. Public Health: Copies of a proposal for a streptoccal survey of children with respiratory infections from selected geographical areas with high incidence of rheumatic fever were circulated. The Communicable Disease Committee recommends Council approval.

ACTION:

It was voted to approve the streptoccal survey.

Swine Flu: Dr. Kuboyama reported that he attended a regional meeting of the National Influenza Immunization Program in San Francisco, California, on July 22, 1976. A summary of the proceedings of the meeting was circulated. Dr. Kuboyama recommended that the Council go on record as not opposing the Department of Health to proceed with a mass immunization program for swine flu, and to ask physicians to inform their patients regarding procedures to be followed.

ACTION:

It was voted to reaffirm the previous stand of the Council on swine flu.

Cervical Cancer Program: The Cancer Center of Hawaii has asked the HMA to develop a referral list of physicians specializing in problems associated with uterine cancer. A similar listing has been developed for patients seeking referrals under the breast cancer project.

ACTION:

It was voted to send a letter to the membership asking for participation in the cervical cancer screening program referral service.

C. Internal Affairs: Dr. Sloan reported that the preliminary program for the 1976 annual meeting will appear in the July issue of the HAWAII MEDICAL JOURNAL. He also noted that the Convention Committee for 1977 has been in contact with the AMA regarding the possibility of conducting an AMA Regional CME Meeting in conjunction with the HMA Annual Meeting in 1977. The committee recommends that the Council approve the following recommendations: (1) That the HMA-AMA meeting be held from October 30-November 5, 1977, at the Sheraton-Waikiki Hotel; (2) That the Council concur with the AMA's expanded program format with approximately 30 postgraduate courses (estimated registration

of 1,000-1,500 physicians); (3) That the HMA registration fee for non-member physicians be $25 and that these funds be used to defray HMA expenses; and (4) That the AMA be requested to allow HMA members to pre-register for the postgraduate will actively publicize this meeting to its members and urge all to register for the courses.

ACTION:

It was voted to approve recommendations (1), (2), and (4). It was further voted to approve recommendation (3) with a change in the amount of the registration fee to $50 for non-member physicians.

D. Diabetes Task Force: Mr. Won reported that the *ad hoc* Medical Research Task Force which was given Council approval to proceed with the development of a diabetes proposal under PL 93-354 has been actively meeting under the chairmanship of Dr. Winfred Y. Lee. The task force is presently formulating ideas for the development of a Diabetes Education and Research Center. The goals and objectives for the Center as well as the proposed organizational structure were circulated for Council perusal.

E. Cancer Commission: Dr. Dang reported that the Cancer Commission met on July 23 and discussed the proposed move of the Hawaii Tumor Registry from 800 Bishop Street to 320 Ward Avenue. It was unanimously voted to move the Tumor Registry to 320 Ward Avenue and the Cancer Commission asked that the HMA do everything that it can to make the move as expeditious and as easy as is possible.

F. Search Committee: Dr. Dang reported that the *ad hoc* Search Committee met immediately prior to the Council meeting and considered a replacement for Mr. Tom Thorson, Executive Director, who plans to retire at the end of 1976. The committee unanimously approved and recommended Council approval of Mr. Jon R. Won to succeed Mr. Thorson.

ACTION:

It was voted to approve the recommendation.

G. Cancer Center: The Cancer Center of Hawaii notified HMA regarding the terms of office for members of the Cancer Center Executive Committee. The terms of HMA representatives Herbert Y. H. Chinn and Thomas Lau are due to expire in September 1976.

ACTION:

It was voted to request that both incumbents be asked to continue as HMA representatives.

H. Peer Review: Dr. Hughes, President of Hawaii County Medical Society, asked for clarification of the role of the HMA, county medical societies, individual members, and hospital staff members with regard to the process of peer review. Attorney Tom Rice reviewed the peer review process in the HMA Bylaws. He noted that the due process system of hospitals is determined and developed by the hospitals and is not within the jurisdiction of the HMA. Mr. Rice also noted that the HMA Peer Review Committee may assist the county medical societies when requested to do so if there are no objections to the review by any of the parties involved. He noted also that the HMA Council would remain as the appellate body should appeal be required. The Council directed the HMA President to meet with the Director of Health regarding the due process mechanism in Act 97 hospitals.

ACTION:

It was voted to direct the HMA President to ask the HMA Peer Review Committee to serve on loan to Hawaii County Medical Society as requested.

I. EMS: Dr. Sia reported that the EMS project has received another grant for 1977. He noted that the executive committee of EMS presently consists of five voting members appointed by the HMA. It is recommended that a non-voting member be added to the board who is an emergency physician.

ACTION:

It was voted that an emergency physician be invited to attend meetings of the EMS Executive Committee when appropriate.

J. Disaster Committee: Mr. Thorson reviewed a draft revision of the Statement of Understanding Concerning Emergency Medical Services During Disasters and recommended Council approval.

ACTION:

It was voted to approve the statement of understanding regarding disasters.

K. Ad Hoc Building Committee: A report on the proposed move to 320 Ward Avenue and a budget recap was circulated to all members of the Council. It was recommended that Council approve a borrowing resolution which will permit the securement of a mortgage and/or the purchase of certain equipment as specified by the Council.

ACTION:

It was voted to authorize a borrowing resolution for $1 million upon the signature of the President and the Treasurer in order to expedite payment and purchase of any article within the limits of the Council authorization and to expedite the securing of a mortgage.

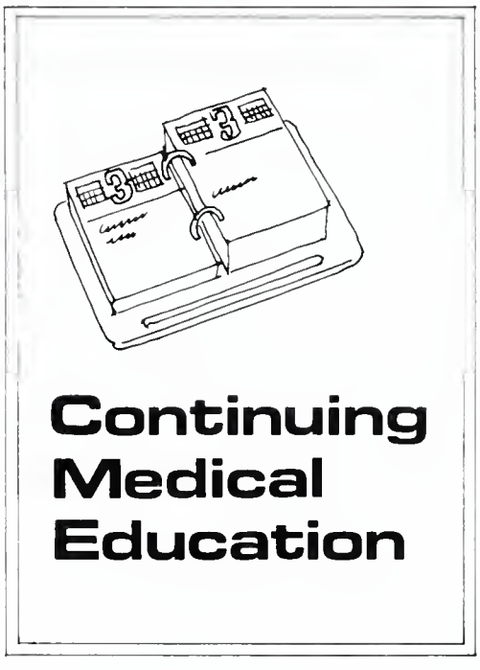
NEW BUSINESS

A. AMA Board of Trustees Election: Dr. George Mills expressed his appreciation to the Council for support of his candidacy to the AMA Board of Trustees. He noted that the election was very close and that he lost by only a few votes.

ADJOURNMENT

The meeting adjourned at 11:35 p.m.

R. VARIAN SLOAN, M. D.,
Secretary



CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m.

John A. Burns School of Medicine

1. University Grand Rounds in Psychiatry, Tuesdays, 10:00-11:30 a.m. at Queen's or St. Francis. (Contact John F. McDermott, Jr., M.D. or Wen-Shing Tseng, M.D. for further info)

Kaiser Hospital
(Contact CME Dept. for further information)

Kauikeolani Children's Hospital
1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program

Kapiolani Maternity Hospital
1. Grand Rounds, Wednesdays, 7:30-8:30 a.m.
2. Resident Conference, Tuesdays (except 1st), 1:00 p.m.
3. Ob-Gyn Department Meeting, 1st Tuesday, 1:00 p.m.
4. UH Seminars, Wednesdays, 3:30 p.m.
5. Perinatal Conference, Thursdays, 3:30 p.m.
6. Tumor Board, 1st & 3rd Fridays, 1:00 p.m.
7. Oncology Conference, 4th Friday, 1:00 p.m.
8. Visiting Professor Program

Kuakini Hospital
(Contact CME Dept. for further information)

The Queen's Medical Center
1. Medical Grand Rounds, Every Friday, 8:00 a.m., Kam Auditorium
2. Surgical Conferences, 1st Tuesday, 4:30 p.m., Kam Auditorium
 Medical-Surgical Conferences, 2nd Tuesday, 4:30 p.m., Kam Auditorium
 Surgical CPC, 3rd Tuesday, 4:30 p.m., Kam Auditorium
 Basic Science Lectures, Every Wednesday 7:15 a.m., Surgical Conference Room
3. Ob/Gyn Conferences, 2nd and 4th Mondays, 12:30 p.m., Blood Bank Conference Room
4. Pathology Conferences, Every Wednesday, 7:30 a.m., Blood Bank Conference Room
5. Pediatric Grand Rounds, 2nd Wednesdays, 12:30 p.m., Harkness 128
6. Orthopedics Conferences, Every Friday (except the last), 7:30 a.m., Blood Bank Conference Room
7. Tumor Conferences, Last Tuesday, 7:30 a.m., Kam Auditorium
8. Urology Grand Rounds, as designated
9. Psychiatry CME Conference, as designated
10. Neurology/Neurosurgery Conference, as designated

Hickam Clinic
1. Clinical Correlation Conference, 1st Thursday, 11:00 a.m.
2. Didactic—our staff, 2nd Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, 3rd Thursday, 11:00 a.m.
4. Radiology Conference, 4th Thursday, 11:00 a.m. (Contact H.P. Stern, Capt, M.D., MC at 449-9742)

St. Francis Hospital
1. Medical Grand Rounds, Tuesday (4th & 5th) 12:30-1:30 p.m. Sull. IV Classroom
2. Un. Medical Grand Rounds—Tuesday 12:30-1:30 p.m. Mabel Smyth Bldg.
3. Surgical Grand Rounds, Fridays (except 4th) 7:30-8:30 a.m.
4. Tumor Conference, Mondays, 7:30-8:30 a.m.
5. Visiting Professor Program
6. Clinical Pathology Topics, Mondays, 10:00-11:00 a.m.
7. Microslide Conferences, Tuesdays, 8:30-9:30 a.m.
8. Bone Marrow Pathology, Tuesdays, 2:00-3:00 p.m.
9. Basic Science Review & Research Conference, Thursdays, 1st & 3rd, 8:00-9:00 a.m.
10. EENT Teaching Rounds, Tuesday (1st) 7:00 a.m.
11. Psychiatry for the Non-Psychiatrist, Tuesdays (2nd) 12:00-1:00 p.m.
12. Surgical Mortality & Morbidity Conference, last Friday, 7:30-8:30 a.m.
13. Saturday Teaching Rounds, Saturdays (except 4th) 7:30-8:30 a.m.

Straub Clinic & Hospital
1. Medical Grand Rounds, first Thursday, 7:00 a.m.
2. Surgical Mortality & Morbidity, 4th Thursday, 7:00 a.m.
3. Quarterly Professional Staff Meetings, (Jan., Apr., Aug., Nov.), 4th Monday, 7:30 p.m.

Wahiawa General Hospital
1. Noon Seminars, 2nd Friday & 4th Tuesday

Wilcox Hospital (Lihue)
1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:30 p.m. & 2nd Wednesday, 12:30 p.m. of each month in the 320 Ward Ave. Building. Contact HMA Office as dates are subject to change.

Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817
At: Honolulu County Medical Society and Local Hospitals, Honolulu
Type: 1, 1 hr/day, 1 day/mo from 12 mos
Fee: None Methods: AV, O, Pan
Dates: All yr, 12 hrs instruction

Telephone Task Force—Hawaii (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817
Type: 1, 1 hr/day, 1 day/mo for 8 mos
Fee: None Methods: AV, Clin C, O, Pan, R
Dates: Arranged; 8 hrs instruction

SPECIAL EVENTS

Oct. 25-29	Hawaii Medical Association Annual Meeting; Ilikai Hotel; contact Bess Chang for further information at 536-7702.
Oct. 25	Fireside Conference (B) Hawaii Thoracic Society, 245 N. Kukui St., Honolulu 96817 Co-sponsor: American Lung Assn. of Hawaii At: Ilikai Hotel, 1777 Ala Moana, Honolulu 96815 Type: C, 1 day Fee: None Methods: AV, Lec, O, Pan 2½ hrs instruc.
Oct. 26, 1976	"Evaluation & Management of Acute Respiratory Failure"—Minicourse—Wahiawa Gen. Hosp.; Medical Staff. 12:30 lunch. mtg., 6:00 p.m. dinner mtg. Cat. 1—4 hrs. credit. Contact Richard P. Tesoro, M.D.
Oct. 26-Nov. 2	Visiting Professorship Program (B) Hawaii Thoracic Society, 245 N. Kukui St., Honolulu 96817. Co-sponsor: American Lung Association of Hawaii At: Major hospitals on Oahu, Kauai, Maui & Hawaii Type: CC Fee: None Methods: AV, BR, Lec, O 6 hrs instruction
Oct. 30	"Deep Venous Thrombosis & Pulmonary Embolism, C. J. Straeley, M.D. Kaiser Pacific Aud., Kaiser Hsp. 7:30 a.m. Sat. morn Ed. Conf. 1 hr. Cat. 1 credit. Contact: Medical Staff Secretaries.
Oct. 30-Nov. 6	Evaluation of Neoplastic Lymphoproliferative Disorders University of Southern California School of Medicine, 2025 Zonal Ave., Los Angeles 90033 At: Hawaii—Mauna Kea Hotel, Mauna Kea Type: C, 7 days 42 hrs instruction
Nov. 4-5, 1976	"Biofeedback; Bodily Control & Therapeutic Application," 6:30 p.m.-10 p.m. ea. evening.

	Cat. I—3½ hrs. cred. Reg. thru Division of CME—U of H; $30.00. Contact: Dr. John Watson.
Nov. 17-24, 1976 & March 13-19, 1977	Diving Medicine (B-50) Undersea Med. Soc., c/o Professor Edward Beckman, University of Hawaii Conference Center, 1960 East-West Road, Honolulu, 96822 At: Kailua Kona Type: C, 8 days Fee: $200 Methods: AV, OP, PP, Lec, O, Sem 25 hrs instruction
Jan. 17-20, 1977	"Ischemic Heart Disease, Problems & Perspectives", Royal Lahaina Hotel, Maui, HI. Cat. I—13 hrs. credit. Contact: Irwin J. Schatz, M.D. or HI Conference Services, P.O. Box 22670, Hono., HI 96822.
Jan. 18-24, 1977	Hawaii Hsp. Medical Staff Conf. (B-350) Estes Park Inst., Box 400, Englewood, CO 80110. 6 days, Fee $175, 30 hrs. To be held at Kauai Surf Resort, Kalapaki Beach, Kauai.
Jan 23, 1977	Cancer in the Aged (B-100). Straub Clinic & Hsp. 888 So. King St., Hono, 96813. Co-Sponsor: American Geriatrics Society. 1 day-6 hrs. Fee $40.

The seminars on "Sexual Counseling: Office Management of Sexual Problems" sponsored by the ACOG and University of Hawaii will be held on the following dates: (20 hrs. credit)

October 18-22 December 20-24
November 22-26

For further information, write to: American College of Obstetricians & Gynecologists, Department of Continuing Education, I.E. Wacker Drive, Suite 2700, Chicago, IL 60601

OUT OF STATE

For information on any out-of-state programs or courses, refer to August 11, 1975 Supplement to JAMA or call the HMA Office.



Correlative Neuro-Anatomy and Functional Neurology, 16th ed.

By Joseph G. Chusid. 448 pp. Price, $10. Lange Medical Publications, Palo Alto, 1975.

As a medical student in 1952, I found the sixth edition of Dr. Chusid's beginner neurology an excellent introduction to the field. As a practicing neurologist, the sixteenth edition strikes me as a most pleasant, most readable, and handy quick reference. During the intervening 24 years, the book has grown from 263 to 448 pages, but this attests to the rapid growth of knowledge in this field, and Dr. Chusid has done a superb job in putting together the most recent material with the old in clear and concise language. The many illustrations and tables are very useful and will be referred to many times.

If one were to fault Dr. Chusid, perhaps it would have to be on the lack of precise references. However, the author has more than accomplished his objective, which is stated as "to present briefly and clearly some of the important structural and functional features of the nervous system as they relate to problems encountered in clinical neurology."

For the price of $10, I feel certain that this soft cover sixteenth edition is a winner and certainly will remain popular with students and practioners alike.

MICHAEL M. OKIHIRO, M.D.

Florence Nightingale

By Elspeth Huxley. 254 pp. Illustrated, $15., Putnam, 1975.

British writer, Elspeth Huxley, combines accuracy, clarity and interesting style in a biography of Florence Nightingale loaded with interest for physicians and medical students. From the welter of Nightingale data, Huxley selects happenings showing how a "well-bred, intelligent, good-looking" girl escaped the 19th Century enslavement of gifted daughters, and without destructive rebellion, and with minimal neurotic invalidism, burst on the world as a nurse with the British army in Crimea. This step launched her own career and the entire modern profession of nursing. In the resultant flood of energy she swept along equally revolutionary changes in modern medicine, hospital administration and public health, pioneering not only in nursing education, but in hospital dietetics, health care of military personnel, and the collection—and use—of vital statistics. Indeed, she initiated the use of modern statistical graphics—"pieces of pie", bargraphs and other helps—so that this woman who encountered such resistance to her ideas, became expert in persuasive presentation.

Two Americans figured in launching her career and immortalizing her memory. Julia Ward Howe's husband, Samuel Gridley Howe, pioneer worker with the blind, listened to her youthful aspirations and encouraged her. Later, the poet Longfellow wrote of her care of sick soldiers at Balclava and called her "The Lady with the Lamp." Considering how she altered the world, she was perhaps even more aptly, "The Lady with the Blow-torch."

PAULINE G. STITT M.D., M.P.H.

Medical Microbiology

By Ernest Jawetz, Ph.D, M.D.; Joseph L. Melnick, Ph.D.; and Edward A. Adelberg, Ph.D., 12th ed., Lange Medical Publications, Los Altos, CA, 1976. Price. $10.00

This 12th Edition of *Review Of Medical Microbiology* in ten different languages attests to the usefulness of this relatively inexpensive textbook in microbiology. It is both thorough and succinct reviewing in excellent fashion basic bacteriology, immunology, and virology, with many brief descriptions of medical mycology and parasitology.

The book is "directed primarily at the medical student, house officer, and practicing physician". Because of its relative paucity of details in describing clinical infections and specific chemotherapy, this text is not very useful for most house officers or practicing physicians. Rather, it will be an important reference source for microbiology and medical students, medical technologists, and infectious disease practitioners.

Letters *continued from 287*

and his subsequent yearly income will be open to garnishment by a court order if he happens to lose his malpractice action.

There have been some reports in some of the medical throw-away journals in which physicians who have "gone bare" without malpractice insurance, claim that they have not been sued. I have read these carefully and the number of physicians operating this way and the length of time for which they have been operating, gives no reasonable credence to the idea that they are "protected," by not having professional liability insurance.

In my estimate, professional liability insurance is really indispensable, especially to the high-risk specialists. What we all are really complaining about is the high cost of this insurance, and the abuses in the legal system which have generated the high cost and created an adversary atmosphere between the physician and his patient.

The New Malpractice Law (Act 219)

Act 219 was an attempt to deal with the many aspects of the professional liability insurance problem and is, therefore, very complex. As all laws, it is a compromise and unfortunately some provisions voted into the law are onerous to physicians. The deletion of other portions of the **proposed** law made us equally unhappy. Unfortunately, many of the proposed changes in the legal system were deleted by the legislative committees considering the Bill. One must understand that the major committees which reviewed this legislation (and made many of the alterations which are now part of the law), are chaired by attorneys with vested interests in maintaining the current professional liability situation. **In spite of the alterations imposed by these men, many aspects of the new law are really good and will benefit both the physician and his patient in the long run.** I trust that physicians considering the professional liability situation will consider the good aspects of Act 219 and not denounce the entire law because of a few bad provisions.

The portion of the law requiring compulsory professional liability insurance for licensure has created the greatest furor and has called all physicians "to the Alamo." This aspect of the law certainly creates many problems and should be repealed or invalidated in the courts. There are moves afoot to do both these things and I trust that that particular "carbuncle" will be lanced appropriately.

When this is accomplished and the problem of compulsory professional liability insurance is solved, we will still have with us the major problem of providing professional liability insurance for the large majority of physicians who feel that this is necessary for their practice. I believe that many of the remaining portions of Act 219 will help us to provide professional liability insurance at a reasonable cost and also to significantly change the adversary atmosphere that has developed in the physician-patient relationship because of the professional liability problem.

Perhaps Act 219 was touted as too much of a "cure" for the professional liability problem. We think of that in terms of a vaccine which could immunize physicians and patients against the virulent effect of plaintiffs' attorneys and courts (in attempting to make an "attorney vaccine," we find that we can easily grind them up fine enough, but they are impossible to **purify**). In spite of the fact that Act 219 has some facets that physicians find difficult to accept, there are some other aspects which should ease the malpractice problem considerably and I have listed these below.

1) **The Medical Claims Conciliation Panel**

This panel will independently review all malpractice claims **before they can be filed as a suit in court.** The panel will hear both the plaintiff and the defense attorneys and any witnesses and then will call its own experts from panels supplied to them by the Medical Society and medical specialty societies. Although the findings of the panel are not admissible as evidence (because this is unconstitutional), the findings of the panel can be introduced after the trial, in order to help assign court costs and attorneys' fees. If the panel reviews a claim and feels that there is no basis for it, and the plaintiff's attorney insists on suing (which is his right under the law), and then loses the case, the findings of the panel can be introduced at the end of the case and the trial judge has the prerogative of assigning all court costs, plus **defense** attorney's costs to the plaintiff. The plaintiff may then turn around and sue his own attorney for malpractice for pursuing a case that had no merit and costing him a great deal of money.

The panel also will separate out individuals named in a suit who obviously should not have been sued (eliminating the "shot-gun" approach to suing everyone involved with a patient). If the plaintiff's attorney persists in his suit against someone whom the Conciliation Panel has cleared and then loses that suit, the physician or hospital who has been wrongly sued may then press an action for abusive process against the attorney and the plaintiff. In the past when this was done, the plaintiff's attorney could always plead ignorance, saying that he did not know that the individual physician was not to blame. He cannot do that once the Conciliation Panel has reviewed the case, because experts have told him prior to trial that the particular individual should **not** be sued. The evidence that the panel has cleared the particular physician can be introduced at the abusive process trial.

2) **The Patients' Compensation Fund**

With this fund the physicians and hospitals

"Our Angels"

	Page
American Security Bank	286
Bank of Hawaii	315
Borthwick Mortuary	309
Century Pacific, Inc. *Jockey Club*	309
Hawaii Bancorporation, Inc.	322
Hawaii Medical Leasing	291
Hawaii Medical Service Association	311
Hawaiian Trust Company, Ltd.	319
Herbert K. Horita Realty, Inc. *Waialae Iki IV*	318
Hilo Care Center	297
Eli Lilly and Company *Keflex*	292
Lydia O'Leary *Covermark*	312
Pathology Associates	290
Pharmaceutical Manufacturers Association	320, 321
Physician's Ambulance Service	314
Professional Calendars, Inc.	310
PVO International *Saffola*	316
Real Estate Finance Corp. *Kailua Village*	313
Roche Laboratories *Valium*	284, 285
Roerig *Atarax*	288, 289

And it's a painful moment, a lonely moment. In spite of your grief, arrangements must be made, details must be taken care of.

At Borthwick Mortuary, we're available at any time to talk with you calmly, openly, and sympathetically. Since 1916, Honolulu families have turned to us at that moment.

We offer a wide choice of facilities and services to make arrangements that suit your individual needs and desires.

In time of need, please call.

There comes a time



Borthwick Mortuary

1330 Maunakea St.
Phone: 531-3566

OWN A PIECE OF THE STRIP!

JOCKEY CLUB

IN LAS VEGAS

Las Vegas' most beautiful condominium resort on the Strip next to the Dunes—across the street from the MGM and the Aladdin Hotel.

Compare your pluses:

Tax shelter
Maximum profit potential
No recession on the Strip

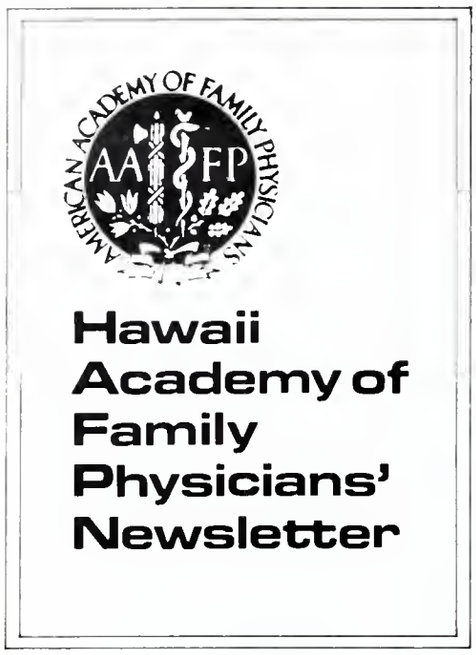
Fortunes are made by being at the right place at the right time. COMPARE this investment with any condominium in Hawaii. *There are over 12,000 unsold units.* (1976 Bank of Hawaii report)

Now is the time to get in on the ground floor before the Jockey Club Casino opens! Single and Hui purchases welcome.

One Bedroom Suites from $52,000

CENTURY PACIFIC, INC.
REALTORS

1027 A Bishop St. Honolulu
Ph. 521-6987



Hawaii Academy of Family Physicians' Newsletter

J. L. Frederick Reppun, M.D.

Boston, 20 September—(dateline)—As this is being written, the 29th meeting of the Congress of Delegates, AAFP, concluded its business and elected **Leslie Huffman,** president 1976-77, **Jack Kelly,** president-elect, **Woody Lewis,** Vice president, **Sam Nixon,** Speaker, **Bob Shackelford** Vice-speaker, and three new Directors: **Wallace Matthews, Willis Irvine** and **Holger Rasmussen.** Hawaii's candidate **Felix Lafferty,** running for the Board of Directors in a field of seven, despite a well-received and lavish Hawaiian hospitality suite and the tremendous effort of his wife **Jewell,** failed in his bid for one of the three slots. The candidates were all high class and the competition fierce.

The 28th Annual Scientific Assembly at Hymes Memorial Auditorium in BACK BAY BOSTON has every course, seminar and Continuing Education Course over-subscribed as swarms of MD's congregate for this popular annual event.

New Members—Processed so far, **Peter J. Leeson, D. O.** who is in Family Practice Residency at Tripler, has joined as an Active member. **Clarissa Tana Burkert** is a new student member. UHSM '79.

Dropped—from our rolls, students **Rakhi Ram, Robert Childs** and **Jonathan Cho,** all new MD's who have gone off elsewhere for Residencies.

TRANSFERRED OUT—Paul Esaki, MD '76 U. of Oklahoma—"I will return," says Paul. **Juan T. Van Putten, MD** has moved to Washington, D. C., **Norman Arai, MD** to FP Residency at Riverside General Hospital; Norman says: "Hopefully I'll be back in another few years."

NEWS OF MEMBERS—Dale G. Wicklund, MD '76 Tripler Army Medical Center. **Verne Adams** of the Big Island is going in for surgery and **Arch Wigle** is looking for a *locum tenens* to cover for Verne.

Identified in the crowd, so far, are **Don Farrell, Marc Shlachter, Homer Benson** and **Fred Reppun** from the Hawaii Chapter.

The opening ceremonies of the Congress of Delegates and the initial session were held in historic 230-year old Faneuil Hall, the "Cradle of Liberty," so called because the town meeting-style forums held therein led up to the Revolution and the Declaration of Independence. A color guard of Charlestown militia dressed in the uniforms of 1776, presented the guests who were thrilled to be reminded by the ancient town-hall, the red, white and blue bunting, the famous view pictured in oil paintings on the walls, that here, our democratic republic was born. As the sun broke through the fog outside, at recess, the delegates wandered through the open markets—traditional for nearly 300 years!

Letters *continued from 308*

(operating throught the state fund), essentially insure themselves from the One-Hundred Thousand Dollar to the One-Million Dollar level. Because re-insurance (for amounts above One-Hundred Thousand Dollars), is almost impossible to obtain, this enables an insurance company which cannot get any re-insurance (such as one perhaps organized by a group of physicians or by the Medical Association or Hospital Association), to go into business and protect their policy-holders to One-Hundred Thousand Dollars through their own company with protection above One-Hundred Thousand being guaranteed through the Patients' Compensation Fund.

Some criticism has been leveled saying that now the attorneys have a "pot of gold" to shoot at. Several suits over One-Million Dollars have been filed in Honolulu over the past several years, without any "pot of gold" to shoot at. An aggressive plaintiff attorney with an aggrieved patient will sue for an amount that he feels is justified (or an inflated amount), whether or not the physician has insurance or there is a Patients' Compensation Fund. One needs only to look at the history of malpractice, both in this state and on the mainland, to see that that is the case. The "pot of gold" has been there all along and the plaintiff's attorneys will not sue for less or be deterred from suing because there is no Patients' Compensation Fund.

Tax Deductible Vacations for Medical Professionals.

Over 500 listings of national/international meetings in the medical sciences for 1977. Send a $10 check or money order payable to Professional Calendars, P.O. Box 40083, Washington, D.C. 20016.

Fast, fast relief for physicians.

We know you'll feel a lot better when your bills get paid promptly. You can get fast service from HMSA if you submit your claims promptly. It will not only keep your accounts current, the cash flow situation in your office will be a lot healthier. HMSA, Hawaii's non-profit medical plan, goes a long way in easing the pains of financial worry.

And we do a better job because of your help.



Hawaii Medical Service Association

3) **Informed Consent**

Act 219 mandates the Board of Medical Examiners to establish a reasonable type of informed consent, document and/or process. If the physician follows this prescribed method of obtaining informed consent, no action can be brought against him for lack of informed consent. One of the big problems on the mainland has been that any complication after surgery has become "malpractice" if the surgeon did not inform the patient about the possibility of such a complication or even if the patient was informed and said, "I didn't understand." With this section of Act 219, the physician is protected provided he follows the prescribed method of obtaining informed consent and the patient will not be able to bring suit on the basis of lack of informed consent. Again, following the history of malpractice on the mainland, a large percentage of cases in the malpractice-prone states with an aggressive plaintiff's bar are being brought based upon lack of informed consent. This section of Act 219 should reduce or eliminate actions brought on this basis.

There are several other aspects of Act 219, which I think will improve the climate for medical care in this state and diminish the number of malpractice suits filed and hopefully significantly reduce the cost for professional liability insurance in this state.

At the present time, the Hawaii Hospital Association and the Hawaii Medical Association are pursuing the idea of a doctor and hospital owned and controlled reciprocal insurance company which hopefully will be able to protect the doctors and the hospitals at a reasonable cost. This really is what most of us are looking for.

ALAN PAVEL, M.D.

In Memoriam



Henry S. Dickson, M.D.

1899-1976

Henry Dickson put in a full day at the office on Friday, 20 August. He had had a few early warning symptoms a day or two before, but on Saturday morning had angina severe enough that he could ignore it no longer; he called the ambulance and had himself taken to Queen's Medical Center Coronary Care Unit. He did well and on the 31st was transferred to a room in the Pauahi wing. The morning of 1 September he expired suddenly. He departed this world as he would have wished: Averse to compliment or to pity, intolerant of the many injustices in this world, and never afraid to speak his piece in trying to make the world better for his fellow man.

In December of 1972 he was honored by his colleagues in the Hawaii Academy of Family Physicians for his 51 years of practice. The occasion was the annual meeting. We reproduce here what was said to him and his family on that occasion; we are glad we were able to honor him in that way in his lifetime.

"As a Nova Scotia lad of sixteen, Henry was already the boss over two ship-unloading gangs. He had been making five dollars a day as timekeeper, plus an extra dollar a day for taking over the ship's winches for the 2-hour noon lunchbreak, at 50 cents an hour. The ship's underwriters, worried over a cargo of flour that



BLEMISHES?

COVERMARK conceals all skin discolorations . . . birthmarks. brown & white patches, broken veins. tattoos. burns. scars. on any part of the body. COVERMARK is also unexcelled as an overall makeup . . . will not rub or flake off. Waterproof and Sunproof.

Lydia O'Leary

OF HAWAII

ALA MOANA CENTER—STREET LEVEL

PHONE 949-3288

was jeopardized by a gaping hole in the ship's side, the result of a near-shipwreck, had offered the lad fifteen dollars a day to be the gang-boss, and then had promised him an additional twenty five dollars for every day under the pre-determined completion date if the job was finished early. He garnered an extra $125 in this way, and developed a reputation for getting things done.

"Wrong profession, you say? Just wait and hear me out.

"He was the only child of a Louisbourg, N.S., sea-captain and his schoolteacher wife. Without seeming to push or urge the lad against his own will, his mother succeeded in getting him to sit primly in a straight chair in the office of Dalhousie University's president in Halifax. Repeated queries by the great man as to the lad's bent and desires brought forth nothing but wordless shrugs of the "don't-know-or-care" variety. Finally realizing he was more than somewhat rude, the lad volunteered that he knew what he was *not* interested in and that was Theology. "Well," said the president of Dalhousie, "the schools of medicine, dentistry and pharmacy are already into their first week; the general colleges of arts and sciences will not open for another two weeks." Because he happened to have a couple of buddies from his home town in the medical college, our boy opted for medicine. How's that for happenstance?

"Even so, it wasn't a sure thing. Our boy was by then a chief engineer on an ocean-going tug and dredge during the summers. A few weeks before the end of his third year, he was approached with an offer to be fourth engineer on a Cunard liner, with the promise of rapid advancement and an assured career at sea. Seeking and accepting his father's advice, however, he decided to finish out the year. And the die was cast. Even earlier, a few months before the Armistice ended World War I, he tried to sneak out of school and enlist in the Royal Canadian Airforce, but was recognized by an examining physician at the induction station and shooed back to medical school.

"Instead of his fourth year at Dalhousie, he got into internship when an opening in the hospital intern staff came about, a year early. He stayed on for another year as intern, got his degree and his license to practice in 1921, when he was 22 years old.

"He took another year of hospital internship at the Royal Victoria hospital in Montreal. He gained a considerable experience in the "medical outdoor" department; the year was aborted, however, and his career in Hawaii initiated, all on the basis of a pair of blue pants!

"Internes had to wear a white shirt, a tie, and white trousers. The Royal Vic laundry had a habit of breaking down and our boy ran out of white pants; so, he put on his "civilian" blues. The nasty Attending noticed this as he began rounds, figured the lad was "predressed" ready to run off to a party on a Saturday afternoon. He deliberately, therefore, prolonged the rounds for an unheard-of three to four hours. This

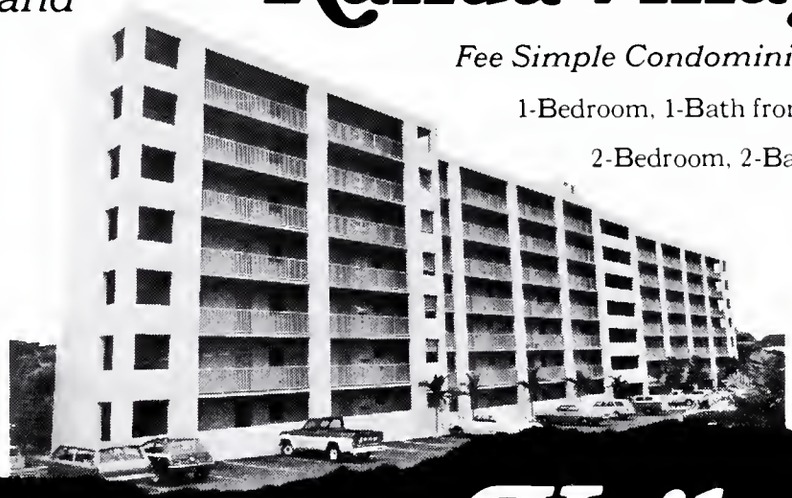
Best buy in Kona for vacations and retirement

Kailua Village

Fee Simple Condominium Apartments

1-Bedroom, 1-Bath from $39,800

2-Bedroom, 2-Bath $79,500 each



One block mauka from Kailua Bay waterfront resort activities. Resale at or below 1974 appraisal of 58 1-Bedroom and four 2-Bedroom units in modern 7-story concrete building with twin elevators, swimming pool, laundry facility. All units include drapes, carpeting, all-electric kitchen appliances including dishwasher, lanai, and assigned parking stall. Nearly 100% occupancy year 'round as rental apartment project since 1973 completion. Purchase on Agreement of Sale or Assumption of Existing Mortgage, depending on unit selected. No closing costs.

Kailua Village

For Information and Brochure, write or phone:
V. L. BOYLAN (R), Principal Broker
IGOR, LTD., 825 Keeaumoku St., Honolulu, Hi. 96814
Bus. 949-8181, Res. 734-1453
GOLD COAST REALTY, Participating Broker
P.O. BOX 631, Kailua-Kona, Hi. 96740 • Phone 329-3155
Model Apt. 329-3321
FURNISHED MODEL APARTMENT ON VIEW DAILY, 10 A.M. — 5 P.M.
Courtesy to brokers

happened several times that month, without a word being exchanged on the matter between the two antagonists. Meanwhile, our interne got wind of an ad appearing in a Halifax newspaper, asking for a doctor to come out to Olaa on the Big Island to help Fred Irwin, also a physician from Nova Scotia. It so happened that Fred's nephew Pete, from McGill, was interning with Henry. The acceptance in pocket, our lad made his final rounds—in blue pants—again prolonged by the assistant professor who was so antisocial—bid the astounded man adieu and departed by train for Vancouver, B.C., thence to San Francisco, and on to Honolulu on the Matsonia. He arrived on the 31st of March 1922.

"His six months at Olaa was interrupted by a quick trip to Honolulu to take the medical licensure exams; one of his co-examinees was Nils Paul Larsen. After a brief locum tenens for Dr. Sam Brown in Hilo, our man arranged two things: (1) To take over Dr. Jeffries' practice in Kona (Jeffries moved to Honolulu), the only other doctor in Kona at that time being our Chisato Hayashi's father, and (2) to have Sarah give up her private duty nursing career in Montreal and come out and marry him, which she did on 2 December 1922.

"The young couple stayed in Kona for 17 years and had three daughters, all of whom became registered nurses.

"In 1940, mainly because of the necessity of providing a proper education for the three girls, our hero sold his Kona practice to young Hayashi, who had returned to take over from his father, and came to the big city of Honolulu, first taking a three-month course in Ob-gyn at the New York Postgraduate hospital. He opened up a brand new office—solo—on the corner of Pensacola and Beretania.

"When the Honolulu County Medical Society organized a medical preparedness committee in March of 1941, it paid off handsomely on 7 December 1941. Harry Arnold Senior was elected Chief of that committee and was deputized as such by the wartime Office of Civil Defense (OCD). Henry was made Medical Administrator for Oahu, under Dr. Arnold, and was put in charge of 20 aid stations in Honolulu. Each one had a cadre of 300. Our man had 400 ambulances at his disposal. By 0930 of that fateful Sunday he had all stations manned and had sent 200 ambulances to serve the military. During the war, since his office was practically across the street from the Kaahumanu school headquarters of the OCD, he was also able to keep his private practice going.

"As the war came to a close, our man accepted an offer to join Dr. Vas Osorio in the Alexander Young building, after Dr. Louis Gaspar had left the latter to set up for himself on Kukui Street. This association lasted only six months, however, until Osorio decided to move to the Mainland, leaving the large practice to his new associate. It was not long before Drs. Ed Chung-Hoon and Ed Cushnie joined him to form a threesome. In the 1950's, they took in Ob-man David Sinclair.

"The Ala Moana building opened in September 1961; the doctors of this group were its first physician-tenants and have listed 1441 Kapiolani as their address ever since. At the move, they were joined by the Bell brothers, Dough and John. Since then there have been comings and goings—including a loss by death, Ed Cushnie. At present, they are six: Dickson, Bell, Bell and Bell, Sinclair and Ching.

"Our Henry still puts in a full time week of active practice. He has given up the trephining of skulls and the major surgery that a GP *had* to do in Kona and was able to continue doing after he moved to Honolulu in the 1940's. He no longer does obstetrics.

"Never one to seek the limelight, Henry does love to work behind the scenes in medical politics. Nevertheless, he became president of the Hawaii County Medical Society, and HMA vice-president in 1934-1935. He joined the Hawaii Chapter of the American Academy of General Practice in September 1951, a year after it was chartered, and is now a Life member. He became a Fellow of the A.A.F.P. a couple of months ago, having been capped and gowned at the charter convocation in New York City.

"Henry is known as one who is not afraid to speak his mind on any subject, but his 51 years of practice have been full of a total devotion to his patients and to his profession. He looks and acts twenty years younger than his 73 years. Were it not for the more important matter of a fiftieth wedding anniversary this very evening (2 Dec 71), he and Sarah would be here with us.

"I give you Henry S. Dickson, M.D., whom the Hawaii Academy of Family Physicians delights to honor."

The Hawaii Academy of Family Physicians, its members and all of his colleagues of the Honolulu County Medical Society and the Hawaii Medical Association are saddened by Henry's passing, and offer to his wife Sarah and his family their condolences.

J. I. Frederick Reppun, M.D.

FULL EQUIPMENT.

FULL SERVICE.

FULL STAFF.

Physician's Ambulance Service.
347 Kuakini St., Honolulu.
Call 531-0477

Hawaii's largest staff of Emergency Medical Technicians, plus two paramedics available for emergencies, all skilled professionals trained in life saving techniques and patient care

For the patient and the doctor Serving hospitals, doctors and rest homes The only member of the American Ambulance Association on Oahu

AMBULANCE ASSOCIATION OF AMERICA

With an entire fleet of Cadillac units, each fully equipped with the finest emergency medical supplies and machinery: cardiac monitors, oxygen, heart-lung resuscitator, incubators, and now phone patch capability can put Physician's Ambulance in touch with doctors and nurses while the unit is en route to the hospital.

Ready

HOW TO GET IT!
HOW TO USE IT!

Ready
CASH CREDIT ACCOUNT

Ready

Ready Cash Credit is an amazingly simple way to get money from Bank of Hawaii any time, and for any reason you may need it. It costs you absolutely nothing until you use it. And you don't have to be a current Bank of Hawaii customer to get it.

How to get a Ready Cash Credit Account. It's as simple as filling out the attached application. Then mail or bring it in to any branch. As soon as your application is approved, and your Ready Cash Credit "line" is set, we'll send your Ready Cash Credit checks to you in the mail. Then you're ready to use your Ready Cash Credit any time you want.

How a Ready Cash Credit Account works. Just by writing a special Ready Check, you can draw on your account any time, anyplace, for any purpose, and for any amount up to your credit limit.

Then, every month, the Bank will send you a statement showing you how much of your line you've used, the interest on that amount, and how much you owe. Your statement will also show the balance you still have available to use. You can repay what you've used in one lump sum, or in monthly increments. You'll also have a check register, just like a regular checking account, for your own records. And remember, you don't have to keep reapplying for your Ready Cash Credit line. It keeps rebuilding automatically as you pay on it. So in effect, you've got a permanent loan ready to use whenever you want it.

Sign up for your Ready Cash Credit Account today. Then you'll have money in the Bank that's ready to use whenever you want it.

And don't forget if you're already a good Bank of Hawaii checking account customer, you automatically have CoverCheck privileges. That means you'll probably never bounce a check again. Because, if you should overdraw your regular account, CoverCheck covers you to the limit of your credit. It costs nothing until you use it. And your monthly statement keeps you up-to-date on both CoverCheck and Ready Cash Credit.

So check out CoverCheck, too, while you're looking into Ready Cash Credit. This way you're covered for sure.

BANK OF HAWAII
READY CASH CREDIT
AGREEMENT

☐ METHOD 1 — **READY CASH**

Advances under this method shall be made when Borrower completes a special check form, to be supplied by Bank to Borrower, drawn against Borrower's maximum credit. If Bank so requires, each such check shall be for not less than $50 and shall be used only for the purpose of drawing against Borrower's maximum credit. Payment by Bank of the amount of such special check shall constitute a loan by Bank to Borrower of the amount so paid.

☐ METHOD 2 — **COVERCHECK**

Advances under this method shall be made by means of an automatic advance credited directly to a regular checking account which Borrower agrees to maintain with Bank so long as credit is available to Borrower hereunder. Such advances shall be, in an amount sufficient to cover the exact amount of overdraft hereafter described, or the unused balance of Borrower's maximum credit if less than the amount of said overdraft. Such advances shall be made at any time withdrawals by check or use of a card issued by Bank ("Card"), or charges of Bank to said checking account are in excess of the balance of said checking account. Any such withdrawal, including those by any present or future authorized agent, against or charges of Bank to said checking account in excess of the balance of said checking account shall be deemed by Bank to be a request for credit under this method, and an automatic advance by Bank as herein provided shall be a charge against Borrower's maximum credit and shall constitute a loan by Bank to Borrower of the amount so advanced.

The undersigned, hereinafter referred to as "Borrower," has requested a revolving line of credit with Bank of Hawaii, hereinafter referred to as "Bank." Borrower has submitted a credit statement to Bank, and Borrower warrants the truth and correctness of all of the information set forth therein and hereby authorizes Bank to make other inquiries with respect to the finances, character and income of Borrower at any reference provided by Borrower or any place of employment of Borrower. Borrower agrees that the credit statement shall remain Bank's property. Borrower agrees to furnish Bank from time to time with financial statements promptly upon request of Bank and in such detail as Bank may require.

Bank shall make advances to Borrower, subject to the terms and conditions set forth herein, up to the amount of maximum credit approved by Bank set forth above (hereinafter referred to as "Borrower's maximum credit"). Each advance by Bank to Borrower hereunder shall constitute a loan by Bank to Borrower as of the date the advance is made and shall be made in accordance with the method approved by Bank as indicated and described above. Bank may but shall not be obligated to make any advance under this Agreement which will increase Borrower's outstanding loans above Borrower's maximum credit.

Borrower shall be liable for all personal checking account withdrawals given and Covercheck extended to any authorized person by using a bank card, including use in CashTel Automatic Teller. Such withdrawals given or credit extended to minor member of Borrower's family on basis of a bank card shall be conclusively deemed to be for a necessity of life. Borrower shall promptly notify Bank of loss or theft of bank card and be liable for unauthorized use to the extent of $50 prior to such notification.

The following portions of your Bank of Hawaii Ready Cash Credit Agreement in "Large Type" contain important information, disclosure of which is required by Federal law.

Borrower promises to repay Bank all sums loaned hereunder, and until they are repaid, to pay FINANCE CHARGES computed daily on the principal balance of all such sums outstanding at the end of each day after deducting all payments applied thereto and all credits for that day (hereinafter referred to as the "Daily Loan Balance") at the following rates:

When the Daily Loan Balance is	The Daily Periodic Rate of FINANCE CHARGE is	The ANNUAL PERCENTAGE RATE is
Up to $3000	.0411%	15.0%
$3001 to $5000	.0370%	13.5%
5000 and Over	.0329%	12.0%

Payments will be applied by Bank first to FINANCE CHARGES already billed, next to the Daily Loan Balance and the remainder to FINANCE CHARGES accrued but unbilled. Because FINANCE CHARGES are computed on each Daily Loan Balance outstanding, there is no period of time within which Sums Loaned can be repaid without incurring FINANCE CHARGES, but no FINANCE CHARGE will be computed on accrued FINANCE CHARGES, whenever paid.

Borrower promises to pay Bank on account each month on the monthly payment due date approved by Bank set forth above, installments on the Daily Loan Balance, as follows:

WHEN THE DAILY LOAN BALANCE ON THE STATEMENT DATE IS	MINIMUM PAYMENT THAT MONTH IS
Up to $ 600	$ 30
$ 601 to 800	40
801 to 1,000	50
1,001 to 1,200	60
1,201 to 1,400	70
1,401 to 1,600	80
1,601 to 1,800	90
1,801 to 2,000	100
2,001 to 2,500	125
2,501 to 3,000	150
3,001 to 3,500	175
3,501 to 4,000	200
4,001 to 4,500	225
4,501 to 5,000	250
5,001 to 6,500	325
6,501 to 8,000	400
8,001 to 10,000	500

together with FINANCE CHARGES accrued through the statement date unless a lesser amount will pay the Daily Loan Balance on the statement date in full, together with FINANCE CHARGES thereon, in which event Borrower promises to pay such lesser amount on the monthly payment due date. Borrower further promises to pay Bank on demand any amount by which the sum of Borrower's Daily Loan Balance and accrued FINANCE CHARGES exceed Borrower's maximum credit.

At any time, whether or not Borrower is then in default in the Ready Cash Method 1 account hereunder, Bank may, but shall not be required to, set off any amount or amounts owed by Bank to Borrower, or to any indorser or guarantor of Borrower's obligations hereunder, against any indebtedness under this Agreement, without prior notice or hearing or first resorting to any collateral held by Bank and without prejudice to any other rights or remedies of Bank.

To secure Borrower's payment and performance of all obligations hereunder, Bank shall have a security interest in all property and assets belonging to Borrower or any indorser or guarantor of Borrower's obligations hereunder, which are in possession or control of Bank, except real property which is used or expected to be used as their principal residence, and with respect to such collateral the parties shall have the rights and remedies provided herein or otherwise by law except as modified herein.

The terms hereof may be changed by Bank at any time, provided that Bank shall mail or deliver to Borrower the revised form of Borrower's Bank of Hawaii Ready Cash Credit Agreement or other written disclosure of the change (if it is other than a reduction in the minimum monthly payment or a reduction in the periodic rate) not less than fifteen (15) days prior to the beginning of the billing cycle within which such change will become effective or before first use of account by Borrower.

Whenever Borrower is in default hereunder, or Bank in good faith believes that the prospect of payment or performance of any of Borrower's obligations hereunder is impaired, Bank may cause part or all of the outstanding balance of all loans made hereunder to become immediately due and payable and may cause part or all credit available hereunder to terminate, all without demand or notice. In addition, any party to this Agreement may terminate the credit available hereunder at any time by giving written notice to the other party. Termination shall not affect the obligations of Borrower to repay, in accordance with the terms of this Agreement, all loans made hereunder together with FINANCE CHARGES thereon.

Borrower shall be in default under this Agreement when any financial statement or other representation furnished or made by Borrower to Bank is false or breached, or if Borrower fails to inform Bank of any material change in Borrower's financial condition, or if Borrower shall fail to make any payment as herein agreed to or fail to observe or perform any of the agreements or conditions herein, or when any event occurs which results in the acceleration of the maturity date of any obligation of Borrower to others, or when any indorser or guarantor of any of the indebtedness terminates the indorsement or the guaranty or defaults in any obligation to Bank or upon death, dissolution, termination of existence, bankruptcy, insolvency, business failure, or appointment of a receiver for Borrower or any indorser or guarantor of any of the indebtedness or of any property of the Borrower or any such indorser or guarantor, or Borrower is named as defendant in any garnishee process.

Borrower agrees to pay to Bank any deficiency remaining after disposition of collateral, if any, and all expenses, including without limitation, reasonable attorney's fees, collector's fees, and legal expenses, which Bank may incur in determining, protecting, enforcing, or exercising its interests, rights or remedies hereunder, either upon demand or as loans hereunder in which event they may be added by Bank as a loan to Borrower's Daily Loan Balance, at Bank's option.

Borrower and every guarantor and indorser waives diligence, demand, presentment, and notice and protest of dishonor, and consents to any and every extension or postponement of the time of payment (including multiple extensions for longer than the original period), release or substitution of collateral, failure to apply deposit, dispose of collateral or other impairment or suspension of the Bank's remedies or rights against any party or property, all notice thereof being waived.

Except as otherwise expressly stated herein, whenever notice is required, including notice of any intended public sale or of the time after which any private sale or other disposition of collateral is to be made, reasonable notice shall be deemed to be five days. Notice to Borrower or any indorser or guarantor shall be deemed to have been given upon the mailing thereof, postage prepaid, to the address thereof as it appears herein or to such other address as shall have been furnished to Bank in writing or to the last address thereof known to Bank. Remedies of the Borrower or any guarantor or indorser for Bank's sale or other disposition of collateral without required notice shall be limited to those expressly stated in Section 9-507(1) of the Hawaii Uniform Commercial Code and except to the extent provided therein, they shall not be relieved thereby of the above-described obligation for any deficiency.

Borrower's monthly statement, which shall show all payments made hereunder by Borrower to Bank since Borrower's prior monthly statement, shall constitute Borrower's receipt for such payments from Bank.

Borrower warrants the correctness of the information set forth on any application for credit furnished to induce Bank to extend credit under this Agreement and hereby authorizes Bank to make other inquiries with respect to the finances, character and income of Borrower at Borrower's place of employment or elsewhere from time to time.

Time and each of the terms, covenants and conditions hereof are hereby declared to be of the essence and no indulgence or acceptance by Bank of delinquent or partial payments constitutes a waiver of Bank's rights or of any provision of this Agreement. No waiver of any existing default shall be deemed to waive any subsequent default.

Borrower's rights hereunder are not subject to assignment without consent of Bank. This Agreement shall inure to the benefit of and shall be binding jointly and severally upon all signing as Borrower and their heirs, personal representatives, successors and assigns. The term "Borrower" shall include the plural, and shall include the feminine when Borrower is a female.

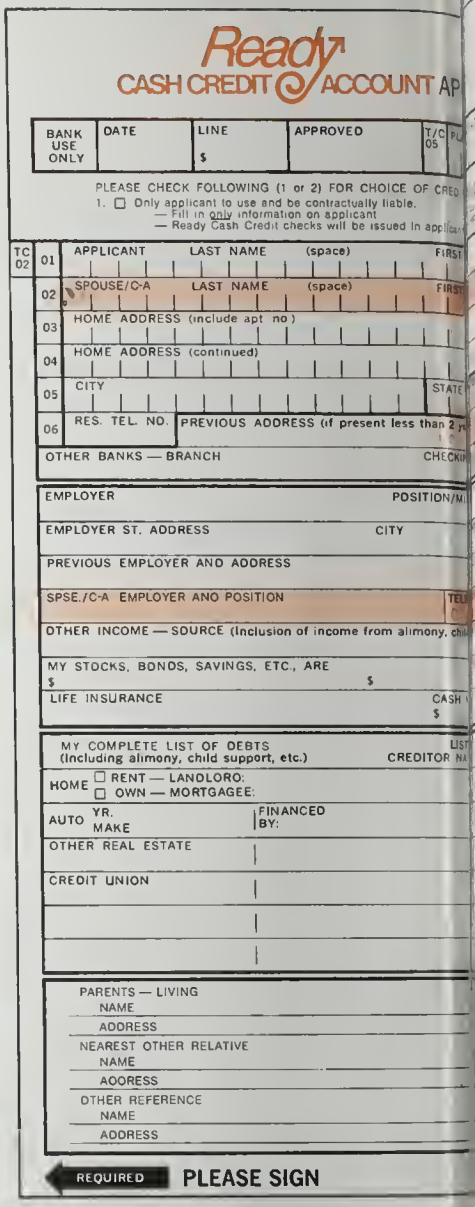
BORROWER
Signature

BORROWER (SPOUSE OR CO-APPLICANT)
Signature

.....
Address

Dated, 19.....

(Signed) BANK OF HAWAII, 800 NUUANU AVE., HONOLULU, HI 96817



Ready CASH CREDIT ACCOUNT AP

BANK USE ONLY | DATE | LINE $ | APPROVED | T/C 05 | PU

PLEASE CHECK FOLLOWING (1 or 2) FOR CHOICE OF CRED
1. ☐ Only applicant to use and be contractually liable.
— Fill in only information on applicant
— Ready Cash Credit checks will be issued in appl

TC 02
01 APPLICANT LAST NAME (space) FIRST
02 SPOUSE/C-A LAST NAME (space) FIRST
03 HOME ADDRESS (include apt no.)
04 HOME ADDRESS (continued)
05 CITY STATE
06 RES. TEL. NO. PREVIOUS ADDRESS (if present less than 2 y

OTHER BANKS — BRANCH CHECKI

EMPLOYER POSITION/M
EMPLOYER ST. ADDRESS CITY
PREVIOUS EMPLOYER AND ADDRESS
SPSE./C-A EMPLOYER AND POSITION TELE
OTHER INCOME — SOURCE (Inclusion of income from alimony, chi
MY STOCKS, BONDS, SAVINGS, ETC., ARE $ $
LIFE INSURANCE CASH $

MY COMPLETE LIST OF DEBTS (Including alimony, child support, etc.) LIST CREDITOR NA
HOME ☐ RENT — LANDLORD: ☐ OWN — MORTGAGEE:
AUTO YR. MAKE | FINANCED BY:
OTHER REAL ESTATE
CREDIT UNION

PARENTS — LIVING
NAME
ADDRESS
NEAREST OTHER RELATIVE
NAME
ADDRESS
OTHER REFERENCE
NAME
ADDRESS

REQUIRED PLEASE SIGN

NAT

BANK OF HAWAII CHK. ACCT. NO.
0

HAVE ENTREE CARD YES ☐ NO ☐

ATUS LINE	ADD.	SHORT NAME

pplicant and spouse or co-applicant to use and be contractually liable.
— Fill in information on applicant and spouse or co-applicant(C-A).
— Applicant and spouse/C-A sign agreement.
— Ready Cash Credit checks will be issued as joint account.

INITIAL	BIRTHDATE / /	U.S. CITIZEN YES ☐ NO ☐
INITIAL	SPSE./C-A BIRTHDATE / /	
	AT ADDRESS YRS. MOS.	NO. DEPENDENTS
	IN HAWAII YRS. MOS.	

SPSE./C-A TEL. NO.	SOCIAL SECURITY NUMBER
DRESS	SPSE./C-A SOCIAL SECURITY NO.
G ☐	BANKAMERICARD NO. 4

	HOW LONG YRS. MOS.	MILITARY PAY GRADE
LEPHONE NO.	YOUR MONTHLY INCOME $	MILITARY SERV. NO.
W LONG /RS. MOS.		MILITARY ENL. EXP. DATE
W LONG YRS. MOS.	SPSE./C-A INCOME +$	MILITARY ROTATION DATE
ional)	OTHER +$	TOTAL MONTHLY INCOME =$

ND ARE COMPRISED OF

COMPANIES

	ACCOUNT NO.	MO. PMT.	BALANCE
		$	$
		$	$
		$	$
		$	$
		$	$
		$	$

OPTIONAL

AUTHORIZATION FOR AUTOMATIC PAYMENT

I WISH THE BANK OF HAWAII READY CASH CREDIT DEPARTMENT TO WITHDRAW — (check one)

☐ THE MINIMUM PAYMENT DUE

☐ THE NEW BALANCE DUE

EACH MONTH FROM MY BANK OF HAWAII PERSONAL CHECKING ACCOUNT.

SIGNED _____

FIRST CLASS
PERMIT NO. 731
HONOLULU, HAWAII

BUSINESS REPLY MAIL

No postage stamp necessary if mailed in the United States

Postage will be paid by: **Bank of Hawaii**

READY CASH CREDIT DEPARTMENT
P. O. BOX 2715
HONOLULU, HAWAII 96803

READY CASH CREDIT FROM BANK OF HAWAII

READY WHEN YOU ARE



Did you ever just want to pack it in on a Friday afternoon? And go to another island? And forget about what the past five days have done to you? But you didn't. Because you didn't have the cash and didn't want to touch your savings and you didn't want to hassle borrowing the money.

Introducing the Ready Cash Credit Account from Bank of Hawaii. Money set aside for you when you want it.

Ready Cash Credit is an amazingly simple way to get money from Bank of Hawaii. How simple? This simple:

Ready

1. Come to any Bank of Hawaii branch. Fill out the handy form.
2. We'll send you our Ready Cash Credit checks via mail after your account has been approved. And remember, Ready Cash Credit costs you nothing until you use it.
3. Your Ready Cash Credit checks can be written anytime, any place, for any purpose as long as you don't exceed your limit. And as you repay, the amount you have available to use builds back up automatically.

The Ready Cash Credit Account is waiting for you, whether you're a Bank of Hawaii customer or not. And once you've got it, you've got it for good. And it's ready when you are.



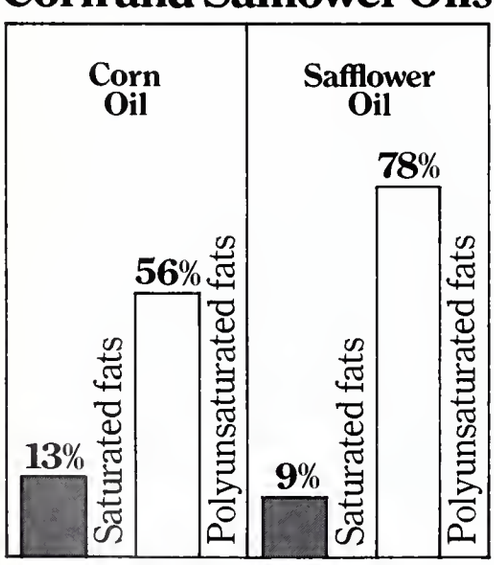
Bank of Hawaii understands.

Member FDIC

The margarine highest in polyunsaturates doesn't contain a drop of corn oil.

Shouldn't you spread that around?

Saturated fats and polyunsaturated fats in Corn and Safflower Oils



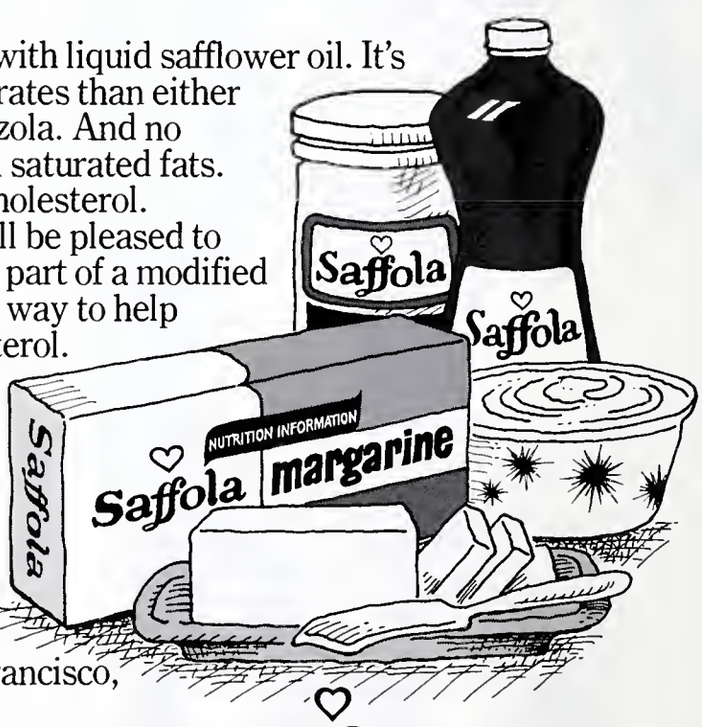
A LIMITED WARRANTY TO CONSUMERS
Good Housekeeping PROMISES
REPLACEMENT OR REFUND IF DEFECTIVE

All Saffola products have earned the Good Housekeeping Seal.

Saffola is made with liquid safflower oil. It's higher in polyunsaturates than either Fleischmann's or Mazola. And no margarine is lower in saturated fats. Saffola contains no cholesterol.

Your patients will be pleased to know that Saffola, as part of a modified fat diet, is a delicious way to help reduce serum cholesterol.

For comparative nutritional information on all of our safflower oil products write: Consumer Products Division, PVO International Inc., World Trade Center, San Francisco, California 94111.



Saffola®

Enjoy it to your heart's content.

Index To Volume 34
SUBJECT AND TITLE INDEX

B

Book Reviews 28, 104, 139, 180, 219, 329
Bromelain as a Skin Cancer Preventive in Hairless Mice 91

C

Carcinoma of the Breast, A Pan-Organ Disease 357
Changing Concepts of Responsibility 389
Ciguatera Poisoning in North West Viti Levu, Fiji Islands 207
Clinical Cytogenetics in Hawaii—An Introduction to Chromosome Abnormalities 355
Clinical Cytogenetics in Hawaii—An Introduction to Chromosome Methodology . 241
Clinical Pathologists Easy Chair 323, 476
Continuing Medical Education 29, 64, 100, 138, 178, 215, 251, 281, 320, 362, 398, 430
Cross-Validation of the Halstead-Reitan Neuropsychological Battery: Application in Hawaii 94

E

Editorials:
Aloha, Ira Hirschy 62
An Open Letter to JCAH 137
Here We Go Again 62
High School Football Injuries 211
Killing the Goose that Laid the Golden Egg 97
"MAC" is Inacceptable 211
Patient! Heal Thyself! 250
Population Control, a la PRC 397
Program for the Family Physician 1 429
Quality of Health Care 177
SN(i)F Has Us in a SNIT 97
Solidarity Forever—Support Your AMA 250
Speciality Recertification Begins 280
The Insurance Will Cover It 317
To Join or Not to Join—That Is the Question 361

F

Football Injuries of the Cervical Spine & Cord 171

H

Hawaii Academy of Family Physicians .. 28, 63, 103, 179, 220, 252, 284, 322, 364, 400, 430
Health Personnel in Hawaii 1820-1974 53
Hemodynamics and Prognosis in Heart Block 133
HMA Council 106, 181, 216, 324, 365, 475
HMA Reports 214
Hospital News 63, 108, 141, 191

I

Impact of Diet Education on the Patient with Adult-Onset Diabetes 174
In Memorium—Doctors of Hawaii
Pinkerton, Forrest Jay 108

J

Japan-Hawaii Cancer Study: A Progress Report 309

L

Letters to the Editor 33, 51, 189, 219, 283

M

Madness in Paradise: Psychiatric Crisis Among Newcomers in Honolulu 275

N

New Members 27, 61, 105, 213, 283, 472
Newsletter 25, 67, 101, 145, 176, 212, 247, 279, 318, 360, 396, 428
Notes & News 30, 66, 98, 143, 186, 224, 253, 285, 330, 368, 400

O

Obituaries—
Seto, Yeun Sang 39

P

Pernicious Anemia in Hawaii-Japanese 425
Plan and Organization for Utilization Review at Queen's 15
President's Message 24, 248
Prevalence of Behcet's Syndrome in Hawaii 244
Proceedings of House of Delegates—119th Annual Meeting 431
Professional Moves 32, 69
Pulmonary Embolism in Hawaii: An Ethnic Study 421

S

Survey for Intestinal Parasites in Oahu School Children 21
Sunshine '75: Rock Medicine Inside Diamond Head 271

AUTHOR INDEX

Arakaki, David 355, 241
Boyar, Jerome 94
Burns, R. Stanley 271
Edynak, Eugene 357
Fukunaga, F. H. 425
Gallup, James 91
Glober, Gary 309
Goebert, H. Wm. 171
Goldstein, Norman 91
Goto, Unoji 15
Gresham, Samuel 15
Henderson, Will 15
Hirohata, Tomio 244
Huffman, Ray 174
Ichinose, Calvin 15
Jimi, Shozaburo 244
Judd, Charles 15
Kaneshiro, M. M. 425
Kimura, Steven 275
Kirk, Stuart 275
Koto, Vernon 91
Kuratsune, Masanori 244
Lerner, Steven 271
Lowrey, John 389
Mikolashek, Patricia 275
Nakahara, Kunihiro 56
Nomura, Abraham 244, 309
Okihiro, Michael 171
Porter, Bruce 421
Rhoads, George 309
Sage, William 15
Schmitt, Robert 53
Sexton, Patricia 271
Sorokin, Michael 207
Stemmermann, Grant 309
Stewart, James 15
Taniguchi, Raymond 171
Taussig, Steven 91
Thomas, Harry 133
Thompson, Henry 15
Tom, Benjamin 15
Tsushima, William 94
Wasnich, Richard 421
Young, Earl 174

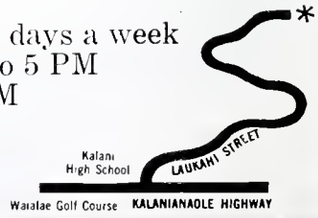


THE FINAL STEP TO THE TOP!

The last of its kind in this area . . . Overlooking Waialae Country Club is a lifestyle that's second to none in custom built homes. Heights of luxury living unfold into a spectacular panorama from Diamond Head to Koko Head . . . sunrise to sunset. Your home design or ours, or a combination of ideas . . . our architects will work with you in this very special exclusive area.

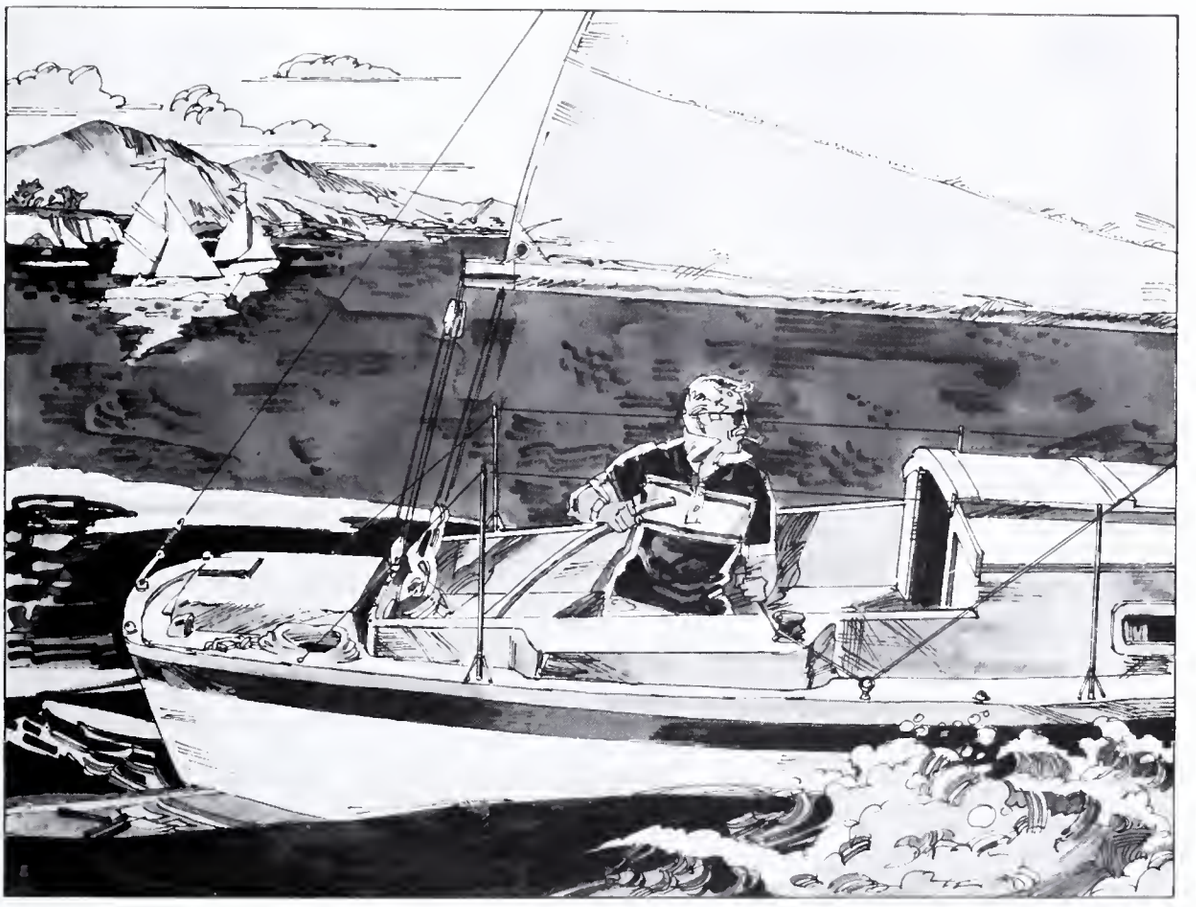
From **$163,400**
55 year lease
Model home open 7 days a week
Weekends 10 AM to 5 PM
Weekdays 1 to 5 PM

WAIALAE IKI IV



Herbert K. Horita Realty, Inc. Kalihi Phone: 847-4241/Waimalu Phone: 487-1561/Waikiki Phone: 922-3377

Retirement. If you're looking forward to it, plan for it.



Too often, retirement counseling is sought too late — just before retirement time. You make decisions that have to be made, rather than those that should have been made years ago. It shouldn't have to be that way. Asset management, annuities, living trusts, joint property, wills. All should be considered and planned well before retirement.

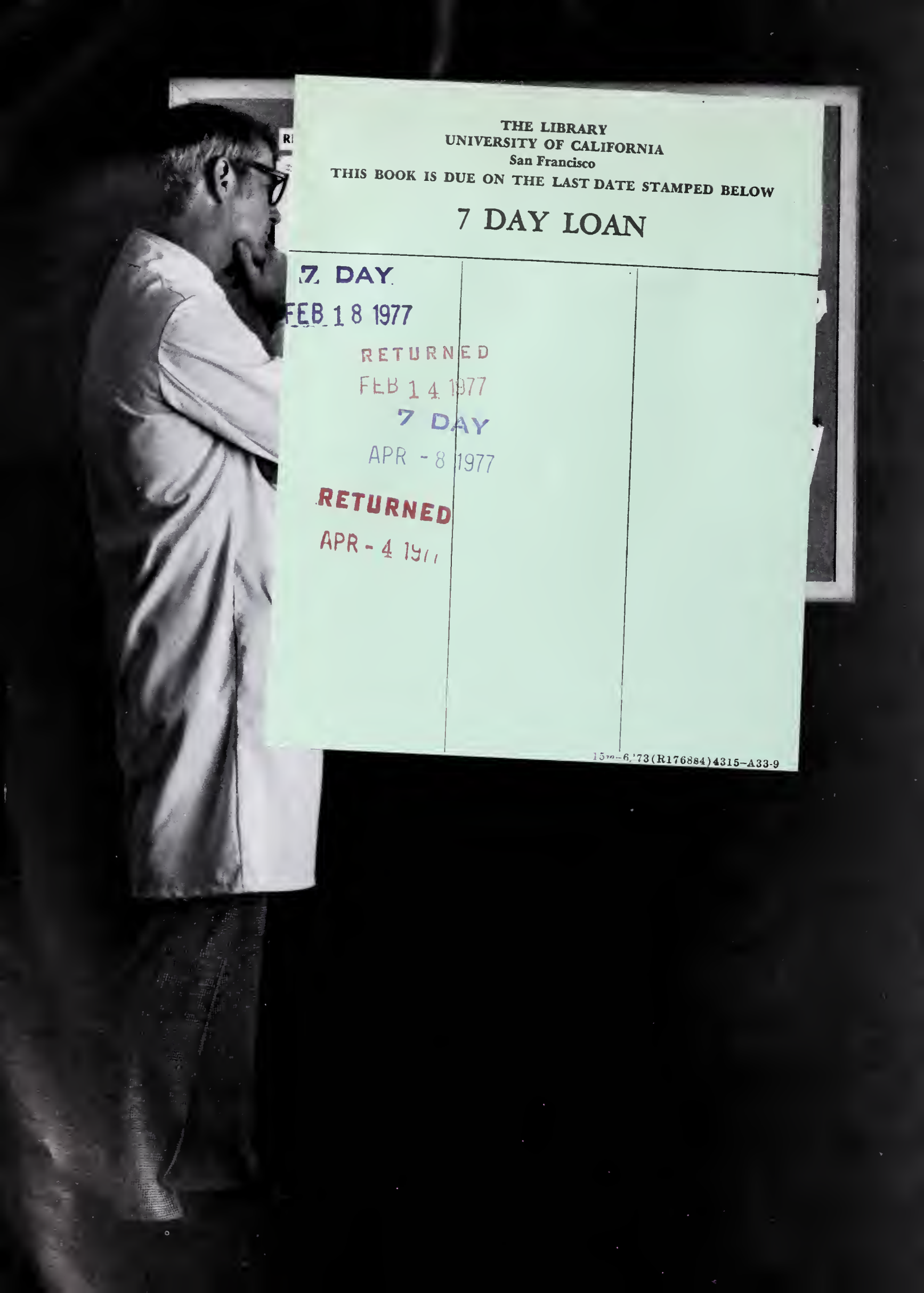
We're specialists in pre-retirement financial planning. With more than 75 years of experience and expertise, we've grown to be Hawaii's largest trust company. We'll meet with you privately or with employee groups. That's only a small part of our service. The major part comes when we work with you to plan ahead.

Planning for your retirement can't come too soon. It can come too late.

Trust Hawaiian.

Hawaiian Trust Company, Ltd.

Financial Plaza of the Pacific • P.O. Box 3170 • Honolulu, Hi. 96802 • 525-8511
Wailuku Town House • Wailuku, Maui 96793 • 244-7965
120 Pauahi Street • Hilo, Hi. 96720 • 961-3784



THE LIBRARY
UNIVERSITY OF CALIFORNIA
San Francisco
THIS BOOK IS DUE ON THE LAST DATE STAMPED BELOW

7 DAY LOAN

7 DAY
FEB 18 1977
RETURNED
FEB 14 1977
7 DAY
APR - 8 1977
RETURNED
APR - 4 1977

15m-6,'73(R176884)4315-A33-9

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.

P·M·A

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

WHY LEASE MEDICAL EQUIPMENT?



It may be just what the doctor should order. Take a moment and look into it.

Why lease? Well, it has to do with money. Your money. We're Bancorp Leasing, and we're an affiliate of Bank of Hawaii. Together, we know a lot about how to make your money work for you. When you lease your medical equipment, you've got your hard-earned money available for other more pleasant or profitable investments. And there's no cash outlay either. Leasing is also a tax deductible expense. Leasing through us leaves you and your staff free of the paper work involved in equipment acquisitions. It's our worry.

Give us a call at 537-8810. If you like, we can make an appointment to come out and see you. There's no obligation. Except our obligation to help you get as much out of your capital as possible.

BANCORP LEASING

A subsidiary of Hawaii Bancorporation, Inc.
and an affiliate of Bank of Hawaii

Hawaii Bancorporation Leasing, Inc. / P. O. Box 2900, Honolulu, Hawaii 96846 / Phone 537-8810

NOVEMBER, 1976
VOL. 35, NO. 11

Hawaii Medical Journal

CONTENTS

The Myths and Magic of Acne Care 333
Richard W. Fardal, M.D.

Sugar Cane Smoke, An Allergenic Agent 336
Carl W. Lehman, M.D.

Continuing Medical Education 342

Editorials 341

Hawaii Academy of Family Physicians' Newsletter 344

HMA Council Meeting 344

HMA Newsletter 340

News & Notes 347

The Library
Acquisitions Division SP
University of California, San Francisco
San Francisco California 94143

LIBRARY
U.C. SAN FRANCISCO
DEC 20 1976

Both often



Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

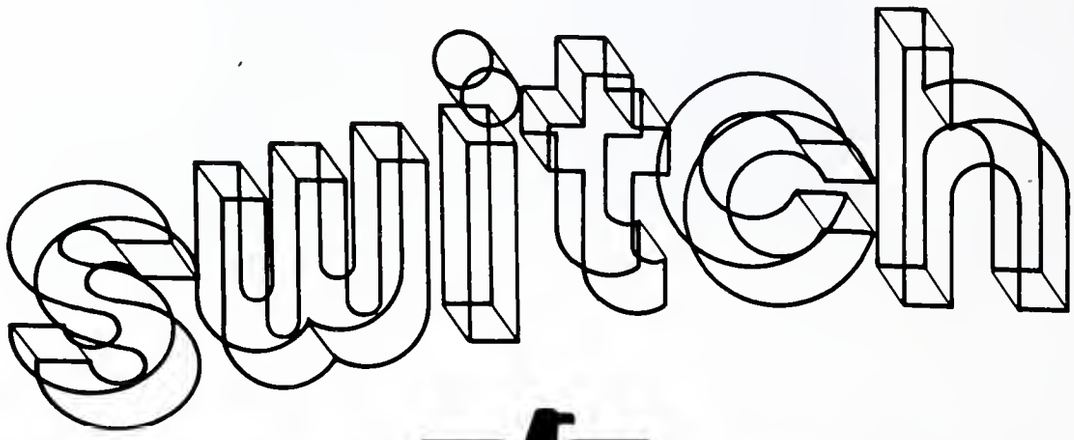
ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc
Nutley, New Jersey 07110

the big mort-gage

home loans to $200,000

Money for the big mortgage isn't always available. But right now American Security Bank has it. The terms are competitive. The service is fast. If you need up to $200,000 to buy that dream home, refinance an agreement of sale or existing first mortgage, call us. Now.



to

American Security Bank

Mortgage Division • 525-7888

EQUAL HOUSING LENDER

Hawaii Medical Journal

Published Monthly by the
HAWAII MEDICAL ASSOCIATION
(Incorporated in 1856 under the Monarchy)
320 Ward Avenue, Honolulu, Hawaii 96814

EDITORS

Editor, HARRY L. ARNOLD, JR., M.D.
News Editor, HENRY N. YOKOYAMA, M.D.
Assistant Editor, DORIS R. JASINSKI, M.D., M.P.H.
Associate Editor, J.I. FREDERICK REPPUN, M.D.
Executive Editor, PAUL STEWARD

OFFICERS

President, CALVIN C.J. SIA, M.D.
President-Elect, MARION HANLON, M.D.
Past President, WILLIAM W.L. DANG, M.D.
Secretary, DOUGLAS B. BELL II, M.D.
Treasurer, GROVER H. BATTEN, M.D.

County Presidents

Hawaii, KENNETH HUGHES, M.D.
Honolulu, ANN B. CATTS, M.D.
Kauai, THATCHER MAGOUN, M.D.
Maui, CLIFFORD MORAN, M.D.
Delegates to AMA, GEORGE H. MILLS, M.D.
HERBERT Y.H. CHINN, M.D.
Alternate Delegates to AMA,
WILLIAM W.L. DANG, M.D.
WILLIAM E. IACONETTI, M.D.

Advertising Representatives
National:
HAWAII MEDICAL ASSOCIATION
320 WARD AVENUE
Honolulu, Hawaii 96814
Phone (808)536-7702
Honolulu:
LILITH JURRY, Phone 946-0053

THE JOURNAL may not be held responsible for opinions expressed in papers, discussions, communications, or advertisements. The advertising policy of the HAWAII MEDICAL JOURNAL is governed by the rules of the Council on Drugs of the American Medical Association. The right is reserved to reject material submitted for editorial or advertising columns. All material for publication must be in the hands of the editor on or before the 10th day of the month preceding publication date. Reprints of original articles will be supplied at actual cost. A reasonable number of illustrations accompanying an article will be accepted for printing. The right is reserved to ask the author to bear cost of these when it is found necessary to do so.

Copyright 1976 by the Hawaii Medical Association, Honolulu, Hawaii. 2nd class postage paid at Honolulu, Hawaii. Office of Publication: 320 Ward Avenue, Honolulu, Hawaii 96814.

OWN A PIECE OF THE STRIP!

JOCKEY CLUB

IN LAS VEGAS

Las Vegas' most beautiful condominium resort on the Strip next to the Dunes—across the street from the MGM and the Aladdin Hotel.

Compare your pluses:

Tax shelter
Maximum profit potential
No recession on the Strip

Fortunes are made by being at the right place at the right time. COMPARE this investment with any condominium in Hawaii. *There are over 12,000 unsold units.* (1976 Bank of Hawaii report)

Now is the time to get in on the ground floor before the Jockey Club Casino opens! Single and Hui purchases welcome.

One Bedroom Suites from $52,000

CENTURY PACIFIC, INC.
REALTORS

1027 A Bishop St. Honolulu
Ph. 521-6987


BREATHABILITY...

In bronchospasm*associated with asthma,
chronic bronchitis, and emphysema

MARAX®

TABLETS: ephedrine sulfate, 25 mg; theophylline, 130 mg; Atarax® (hydroxyzine HCl), 10 mg
SYRUP, per 5 ml: ephedrine sulfate, 6.25 mg; theophylline, 32.50 mg; Atarax® (hydroxyzine HCl), 2.5 mg; and ethyl alcohol, 5% v/v

the only bronchodilating/bronchospasmolytic agent with Atarax® (hydroxyzine HCl) instead of barbiturates, which have the potential to depress respiration



* This drug has been evaluated as possibly effective for this indication. See Brief Summary on following page.



Marax®

TABLETS: ephedrine sulfate, 25 mg; theophylline, 130 mg; and Atarax® (hydroxyzine HCl), 10 mg

SYRUP, per 5 ml: ephedrine sulfate, 6.25 mg; theophylline, 32.50 mg; Atarax® (hydroxyzine HCl), 2.5 mg; and ethyl alcohol, 5% v/v

☐ Marax is the only bronchodilating/bronchospasmolytic agent* with Atarax® (hydroxyzine HCl) instead of barbiturates, which have the potential to depress respiration

☐ Marax contains Atarax to help prevent excessive excitation by modifying the central stimulatory action of ephedrine

* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" Effective: For controlling bronchospastic disorders.
Final classification of the less than effective indication requires further investigation.

Contraindications: Because of the ephedrine, Marax is contraindicated in cardiovascular disease, hyperthyroidism, and hypertension. This drug is contraindicated in individuals who have shown hypersensitivity to the drug or its components. Hydroxyzine, when administered to the pregnant mouse, rat, and rabbit induced fetal abnormalities in the rat at doses substantially above the human therapeutic range. Clinical data in human beings are inadequate to establish safety in early pregnancy. Until such data are available, hydroxyzine is contraindicated in early pregnancy.

Precautions: Because of the ephedrine component this drug should be used with caution in elderly males or those with known prostatic hypertrophy.

The potentiating action of hydroxyzine, although mild, must be taken into consideration when the drug is used in conjunction with central nervous system depressants; and when other central nervous system depressants are administered concomitantly with hydroxyzine their dosage should be reduced.

Patients should be warned—because of the hydroxyzine component—of the possibility of drowsiness occurring and cautioned against driving a car or operating dangerous machinery while taking this drug.

Adverse Reactions: With large doses of ephedrine, excitation, tremulousness, insomnia, nervousness, palpitation, tachycardia, precordial pain, cardiac arrhythmias, vertigo, dryness of the nose and throat, headache, sweating, and warmth may occur. Because ephedrine is a sympathomimetic agent some patients may develop vesical sphincter spasm and resultant urinary hesitation, and occasionally acute urinary retention. This should be borne in mind when administering preparations containing ephedrine to elderly males or those with known prostatic hypertrophy. At the recommended dose for Marax, a side effect occasionally reported is palpitation, and this can be controlled with dosage adjustment, additional amounts of concurrently administered Atarax (hydroxyzine HCl), or discontinuation of the medication. When ephedrine is given three or more times daily patients may develop tolerance after several weeks of therapy.

Theophylline when given on an empty stomach frequently causes gastric irritation accompanied by upper abdominal discomfort, nausea, and vomiting. Administration of the medication after meals will serve to minimize this side effect. Theophylline may cause diuresis and cardiac stimulation. The amount of Atarax (hydroxyzine HCl) present in Marax has not resulted in disturbing side effects. When used alone specifically as a tranquilizer in the normal dosage range (25 to 50 mg three or four times a day), side effects are infrequent; even at these higher doses, no serious side effects have been reported and confirmed to date. Those which do occasionally occur when Atarax (hydroxyzine HCl) is used alone are drowsiness, xerostomia and, at extremely high doses, involuntary motor activity, unsteadiness of gait, neuromuscular weakness, all of which may be controlled by reduction of the dosage or discontinuation of the medication. With the relatively low dose of Atarax (hydroxyzine HCl) in Marax, these effects are not likely to occur. In addition, the ataractic action of Atarax (hydroxyzine HCl) may modify the cardiac stimulatory action of ephedrine, and concurrently, increasing the amount of Atarax (hydroxyzine HCl) may control or abolish this undesirable effect of ephedrine.

Marax syrup contains a tartrazine dye (FD&C Yellow No. 5), which has been shown to rarely produce a variety of hypersensitivity reactions, particularly in aspirin-sensitive individuals.

Dosage: The dosage of Marax should be adjusted according to the severity of complaints, and the patient's individual toleration.

Tablets: In general, an adult dose of 1 tablet, 2 to 4 times daily, should be sufficient. Some patients are controlled adequately with 1/2 to 1 tablet at bedtime. The time interval between doses should not be shorter than four hours. The dosage for children over 5 years of age and for adults who are sensitive to ephedrine, is one-half the usual adult dose. Clinical experience to date has been confined to ages above 5 years.

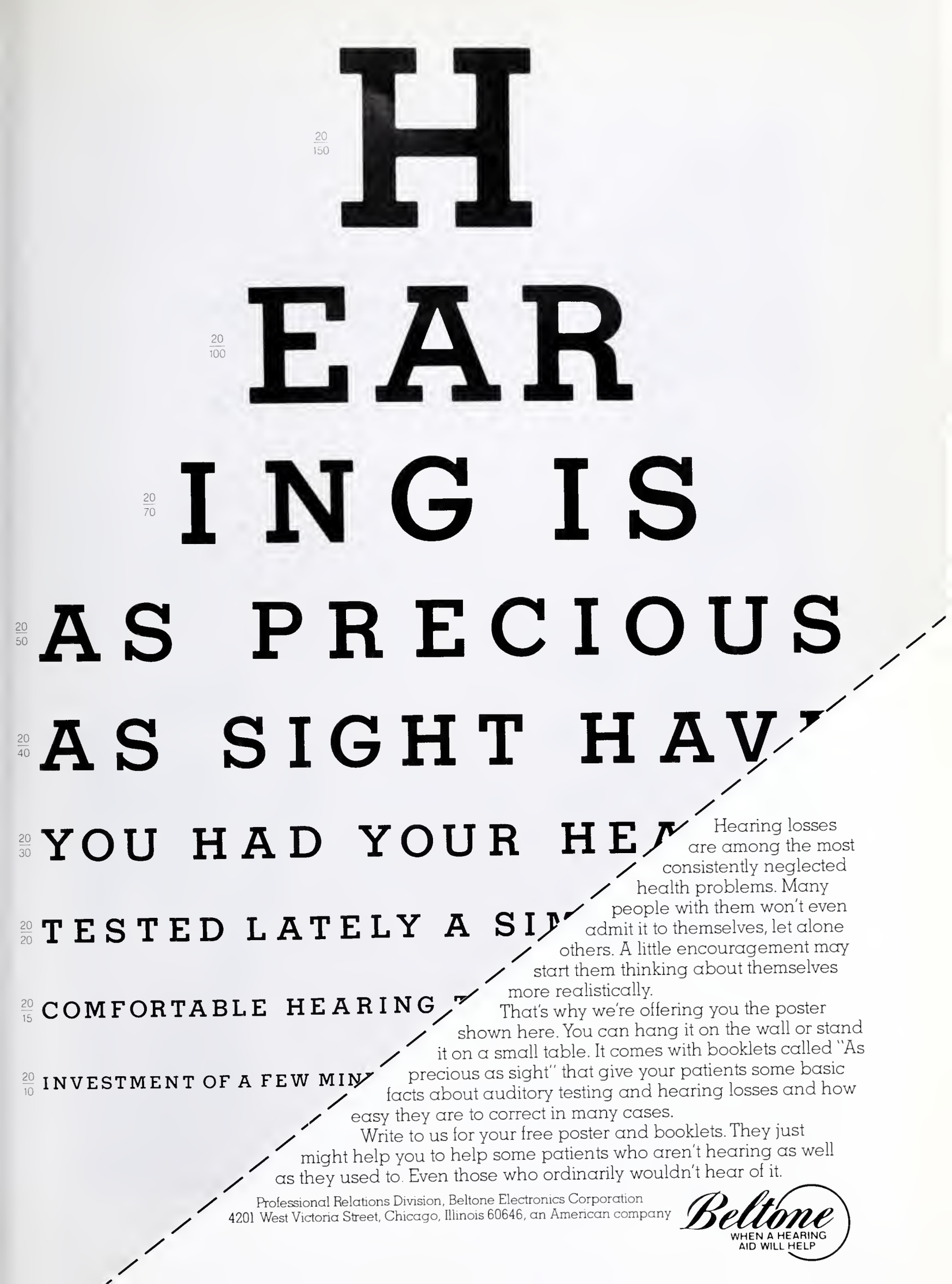
Syrup: The dose for children over 5 years of age is 1 teaspoon (5 ml), 3 to 4 times daily. Dosage for children 2 to 5 years of age is 1/2 to 1 teaspoon (2.5–5 ml), 3 to 4 times daily. Not recommended for children under 2 years of age.

How Supplied: Marax Tablets are available as light blue, scored tablets in bottles of 100 and 500.

Marax Syrup is available in pints and gallons, and should be dispensed in amber-colored bottles.

ROERIG Pfizer

A division of Pfizer Pharmaceuticals, New York, N.Y. 10017



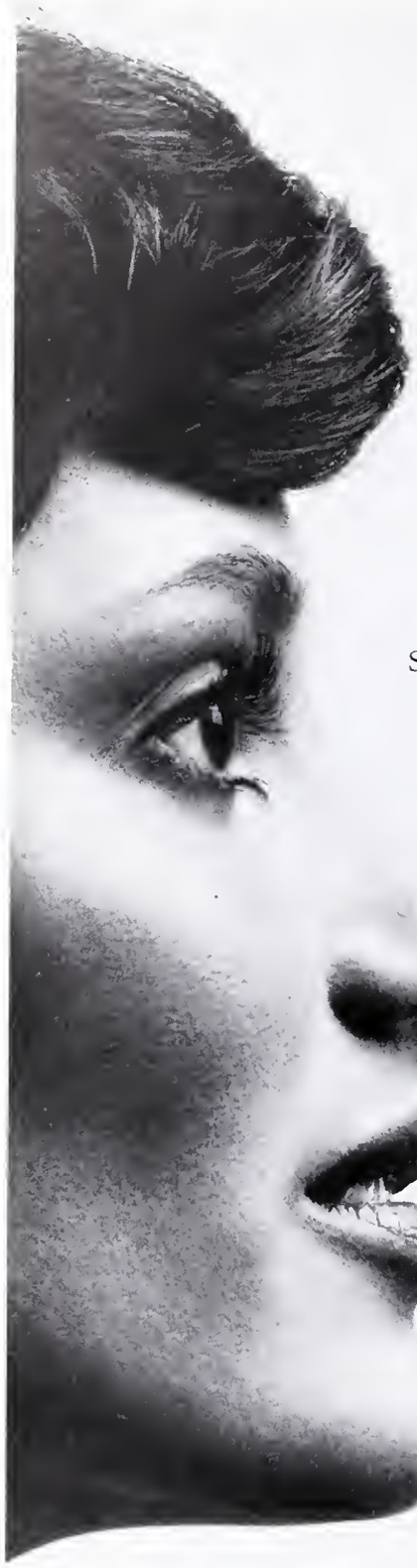
Hearing losses are among the most consistently neglected health problems. Many people with them won't even admit it to themselves, let alone others. A little encouragement may start them thinking about themselves more realistically.

That's why we're offering you the poster shown here. You can hang it on the wall or stand it on a small table. It comes with booklets called "As precious as sight" that give your patients some basic facts about auditory testing and hearing losses and how easy they are to correct in many cases.

Write to us for your free poster and booklets. They just might help you to help some patients who aren't hearing as well as they used to. Even those who ordinarily wouldn't hear of it.

Professional Relations Division, Beltone Electronics Corporation
4201 West Victoria Street, Chicago, Illinois 60646, an American company

Beltone
WHEN A HEARING AID WILL HELP



The one the patient takes is never tested.

Surprising, perhaps, but it makes sense when you think about it.

Obviously, the actual dose of any prescription drug the patient takes cannot be tested because it would have to be broken down for analysis—after which it could never be used by a patient.

This means that you depend on the manufacturer for assurance that the dose the patient takes is identical to the ones which have been tested.

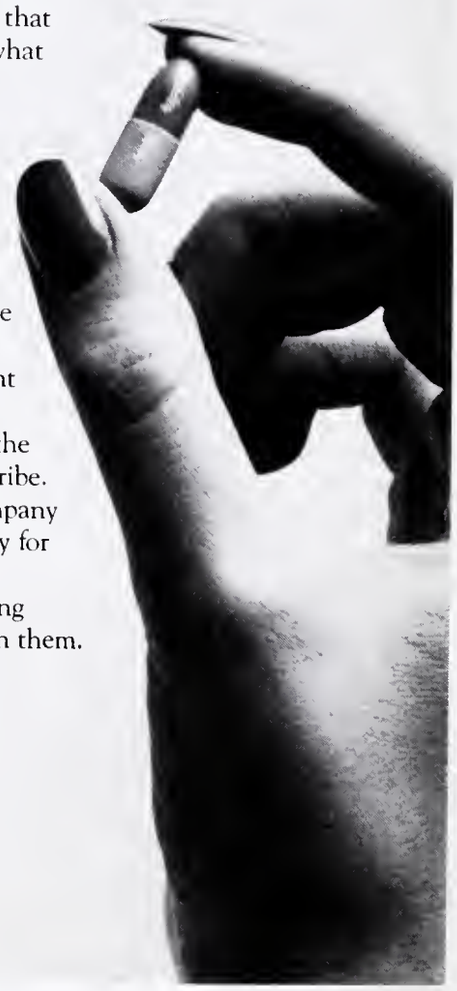
At each step in the manufacture of a Lilly drug, test after test confirms the ingredients, formulation, purity, and accuracy—all the critical factors that assure that every Lilly medicine is just what you ordered.

That's particularly important, as you know. The same drug made by different companies can be chemically identical yet may act differently in the human body because of the many variables in the way the drugs are manufactured.

And, of course, government standards alone do not assure the efficacy and consistency—the quality of each drug you prescribe.

As we at Eli Lilly and Company see it, the ultimate responsibility for quality is ours.

For four generations we've been making medicines as if people's lives depended on them.



600128

Lilly

ELI LILLY AND COMPANY, INDIANAPOLIS, INDIANA 46206

On a very important problem . . .

The Myths and Magic of Acne Care

RICHARD W. FARDAL, M.D., *Honolulu*

• *Acne is never a life-threatening disease, but often one which is life-ruining. Shelley has most accurately described the personal feelings of the acne victim by saying "When we see the disfigurement and discomfort caused by the black comedones, the erythematous papules, the malodorous cysts, the tender abscesses, the draining sinuses and the permanent scars, we sense the feelings of isolation, resentment and unhappiness that acne brings."*[1]

Myths and Folklore

Myths and folklore surrounding acne care are legion. Yet, many recurrent misunderstandings appear. An effort will be made here to dispel some of these myths:

1. "Mr. Clean"—"Acne is easily controlled by adequate and frequent washing." [*It is not*].

2. "Avon Calling"—"Stick with a few popular, widely advertised products for all forms of acne." [*They don't do much good*].

3. "The germs will getcha"—"Long-term antibiotic treatment is dangerous. Limit their use to a few weeks." [*It's* very *safe, even for years of use*].

4. "Everybody's doing it"—"These modern kids have too much sexual stimulation." [*This is irrelevant, whether it's true or not*].

5. "You are what you eat"—"Junk foods" are very harmful. "Natural foods" help. [*They don't*].

6. "Patience is a virtue"—"Acne will go away in a short while." [*It won't, as a rule*].

7. "Scar face"—"Resultant scars are largely due to manipulation or picking." [*Not true*].

"Magic" of acne care comes when the victim and his physician become aware of the pathogenesis of acne. This leads to proper selection of nonprescription and prescription medications for the manifold varieties of acne.

Hawaii Permanente Medical Group
Accepted for publication November 1, 1975

Pathogenesis of Acne

Comedones, the basic lesions of acne, are of two types — the "blackhead" or open comedone, and the "white head" or closed comedone. The color of the blackhead is due to accumulated melanin and occasionally numerous fine "vellus" hairs trapped in the keratin plug. Solvents will extract some of this melanin; thus, the common cosmetic counter ploy of wiping the skin with astringents containing solvents to reveal "deep seated dirt," which is actually melanin.

The white head is the "time bomb" of acne since eventual rupture of extended follicular walls excites a foreign body inflammatory response. The normal bacterial flora of the skin are mainly *Corynebacterium acnes* and *Staphylococcus epidermidis*. The former, a lipophilic anaerobe, thrives in the closed comedo. It digests stagnant sebum, producing irritating short-chain fatty acids.

Healing ultimately occurs by hypertrophic or atrophic fibrosis. The inflammatory reaction may be encapsulated by new epithelial proliferation from follicular wall remnants, leading to cyst formation.

The prepuberal pilosebaceous follicule becomes quite hyperplastic with the androgenic changes of puberty. This stimulation remains maximal in men until old age, but is more cyclic in women and diminishes after the menopause.

Acne will often flare premenstrually. Oral contraceptives, especially those with higher mestranol or ethinyl estradiol content will diminish sebum output and often benefit acne. Safest ones: Enovid, Ovulen, Demulin. See Table 1.

Sebum itself is comedogenic under certain conditions. Pomades, waxes, oils and similar substances will often produce a variety of acne

TABLE 1 — *Commonly Used Oral Contraceptives*

DRUG	ESTROGEN	MG/TAB	PROGESTOGEN	MG/TAB	BIOLOGIC EFFECT
Enovid-E®	Mestranol	0.10	Norethynodrel	2.5	Estrogen-Dominant
Enovid-5®	Mestranol	0.075	Norethynodrel	5.0	Estrogen-Dominant
Ovulen®	Mestranol	0.10	Ethynodiol Diacetate	1.0	Estrogen-Dominant
Demulin®	Ethinyl Estradiol	0.05	Ethynodiol Diacetate	1.0	Estrogen-Dominant
Ovral®	Ethinyl Estradiol	0.05	Norgestrel	0.5	Androgen-Dominant
Norinyl 2® or Ortho-Novum 2®	Mestranol	0.10	Norethindrone	2.0	Androgen-Dominant
Norinyl 1® or Ortho-Novum 1®	Mestranol	0.05	Norethindrone	1.0	Androgen-Dominant
Norinyl 1/80® or Ortho-Novum 1/80®	Mestranol	0.08	Norethindrone	1.0	Androgen-Dominant
Norlestrin 1®	Ethinyl Estradiol	0.05	Norethindrone Acetate		Androgen-Dominant
Norlestrin 2.5®	Ethinyl Estradiol	0.05	Norethindrone Acetate	2.5	Androgen-Dominant

termed chloracne. Prolonged corticosteroid therapy can induce unusual acne where follicular rupture occurs prior to comedone formation. Various drugs, especially iodides, anticonvulsive medications and amphetamines can aggravate acne.

Unbiased, controlled study data generally fail to confirm a significant role for any food in acne. Even large quantities of that old scapegoat, chocolate, do not significantly affect acne or sebum production.

Successful Treatment— The "Magic" of Acne Care

"Magic" #1

Effective agents *must* peel or desquamate rather than merely remove surface soil and cellular debris.

Low concentrations of salicylic acid, resorcinol and sulfur with or without abradant particles are present in most acne scrubs, creams and lotions. They are feebly effective, but are often sufficient to control mild acne.

Sunburn, ultraviolet light, carbon dioxide slush or liquid nitrogen spray are sometimes effective but tedious measures, with problems of pigmentary changes or elastotic degeneration.

Benzoyl peroxide 5 to 10% (Benoxyl, Benzagel, Desquam-X, Loroxide, PanOxyl, Persadox, Vanoxide) is effective, but mildly irritant. Contact dermatitis can occur.

Vitamin A acid or tretinoin (Aberel or Retin-A) cream is the most effective topical agent for mild to moderate acne.[2] Unfortunately, it is also the most irritating until tolerance or "hardening" develops. It increases the rate of production of loose, horny cells in the follicular channel, preventing formation of new comedones and extruding old ones. There is also frequent accentuation of papular or pustular components of acne early in therapy.

Shiny, pink, sensitive, and sunburned faces may result with tretinoin. Patients must be carefully instructed in its use. Generally, it should be the sole topical therapy. Bland soaps and sun screens are desirable. Lipid-free emollients (Cetaphil, WIBI, etc.) can be used. Tretinoin swabs 0.05% are the most rapidly effective, but the most irritating. The creams 0.1 and 0.05% are slower, but are tolerated well by all but the more sensitive patient. Daily use is not essential. Application is usually at bed time, but the skin must be thoroughly dry prior to use.

"Magic" #2

Selection of topical agents must be individualized. Most patients will tolerate nonprescription scrubs and lotions. Use caution with benzoyl peroxide or tretinoin, especially in patients with eczema, excessive sweating, or intensive sun exposure.

Astringents are of no value, since increased sebum output rapidly replaces any loss. There is no evidence that free-flowing sebum and sweat play any role in acne.

Light application of liquid make-ups rarely worsens acne.

"Magic" #3

Long-term antibiotic therapy is essential in most people with moderate to severe acne.[3] Tetracycline is probably the best and least costly antibiotic. Good concentrations occur in sebaceous glands and sebum. Initial doses of 250 mg. three or four times daily may be quickly reduced to once or twice daily maintenance levels. Milk products, iron, and antacids interfere with absorption.

Demeclocycline, minocycline, and doxycycline often are used for initial therapy, but their high cost usually prohibits long-term use. Their main advantage is higher and more prolonged tissue level of drugs than possible with tetracycline. More severe forms of acne may improve faster with their use.

Candidiasis may occur with prolonged use of any tetracycline-type drugs, especially in women who are taking oral contraceptives. Tetracyclines are deposited in growing bones so should not be used in children or pregnant or lactating women. Demeclocycline is by far the most phototoxic of these drugs. Minocycline may produce dizziness unless taken with food.

Clindamycin is very effective. Occasional diarrhea and less commonly, *pseudomembranous* colitis may result. These complications will usually occur early in the course of treatment if at all, and are dose-related. Initial doses should not exceed 150 mg. twice daily in acne.

Erythromycin is the least effective antibiotic. However, recent reports indicate good results with 1-2% solutions applied topically alone or in combination with tretinoin.[4]

Induction of bacterial resistance is never a significant problem in long-term, low dose therapy, using any of these drugs. They act by suppressing *C. acnes* and its lipases which normally digest triglycerides in sebum, producing irritating, short-chain fatty acids.

"Magic" #4

Sebaceous gland activity is stimulated by androgenic steroids, especially progesterone and testostone. The latter is the most potent stimulant. Hot weather, intensive exercise, amphetamines, and even caffeine similarly prompt sebum outflow.

Sexual activity has little or no effect on acne. Hereditarily determined end-organ sensitivity to androgens seems the real problem.

Estrogen-dominant oral contraceptives are often beneficial in women with acne. Conversely, androgen-dominant types may worsen it.[5] Sebaceous glands of women's jaws and neck seem especially sensitive to minute quantities of endogenous or exogenous androgens.

"Post-pill" acne is commonly seen as increasing severity of acne a few months after discontinuation of oral contraceptives. The same effect may occur post-partum.

"Magic" #5

Acne in younger adolescents seems to occasionally worsen with chocolate, cola or nuts. The role of salty foods and iodides is controversial, but probably nil. Older adolescents and adults are almost never affected by diet.

There is no conclusive evidence that any food is either beneficial or harmful to acne. However, I admit requesting my youngest patients to avoid excessive chocolate, cola, nuts, and salt.

"Magic" #6

All but the mildest acne should be appropriately treated for as long as necessary regardless of age. Menopause will often terminate acne, providing one of the few benefits of aging.

"Magic" #7

Proper and early treatment should minimize scarring. Control severe acne as rapidly as possible or refer these patients to dermatologists. Frequent visits and acne surgery are essential in severe acne. Do not hesitate to use oral steroids for a few weeks in these cases. The prednisone equivalent of 20 to 40 mg. daily coupled with adequate dosage of antibiotics usually dramatically improves severe acne. Intralesional steroid injections are best left to the dermatologist or plastic surgeon.

Cryotherapy with liquid nitrogen spray or carbon dioxide slush is effective, but may cause hyperpigmentation. The advent of benzoyl peroxide and tretinoin has decreased the need for freeze peeling.

Dermabrasion should be left to the plastic surgeon or dermatologist skilled in its use. Proper selection of candidates is essential.

REFERENCES

1. Shelley WB: Consultations in Dermatology with Walter B. Shelley. W.B. Saunders. Philadelphia, 1972.
2. Kligman AM, Fulton JE Jr, Plewig G: Topical Vitamin A Acid in Acne Vulgaris, *Arch Dermatol* 99:469-476, 1969.
3. Cunliffe WJ, et al: Tetracycline and Acne Vulgaris: A Clinical and Laboratory Investigation, *Brit Med J* 4:332-335, 1973.
4. Fulton JE Jr, Pablo G: Topical Antibacterial Therapy for Acne. *Arch Dermatol* 110:83-86, 1974.
5. Barranco VP: Effect of Androgen-Dominant and Estrogen-Dominant Oral Contraceptives on Acne, Cutis 14:384-386, 1974.

Sugar Cane Smoke, an Allergenic Agent

CARL W. LEHMAN, M.D., *Honolulu*

● *A clinical study using an extract of sugar cane smoke revealed that many allergic patients previously exposed to the smoke from burning sugar cane developed a positive intracutaneous whealing response, whereas a control group of allergic patients who had not been exposed to sugar cane smoke had insignificant intracutaneous whealing responses. From the histories and results of intracutaneous testing, this study indicates the presence of an allergenic substance in the smoke from burning sugar cane.*

Cane sugar is obtained from juice expressed from sugar cane stalks. The associated foliage, which constitutes a large amount of tonnage, is burned at harvest time; the stalks do not burn. Thus, the efficiency of harvesting cane is enhanced by burning the sugar cane fields.

A number of allergic patients under my care gave histories of their allergic symptoms being aggravated when they were exposed to smoke from the burning of sugar cane fields.

Case Report

The following case report prompted me to undertake this study:

D.J., age 4, had lived in Iowa until three years of age, during which time he was essentially asymptomatic. When the family was transferred to Hawaii, they moved into a home surrounded by sugar cane fields. The mother noted that within one month of living in that area the patient developed nasal congestion associated with exposure to "sugar cane smoke." His nasal symptoms progressively became more severe, and he started to have asthmatic attacks which also seemed to be provoked by exposure to sugar cane smoke. The family moved to another area approximately five miles from their first home, where the patient had minimal exposure to sugar cane smoke. His nasal congestion and asthma improved considerably, but these symptoms did recur occasionally. The patient and his mother vacationed in the Midwest for a seven-week period, during which time he was completely asymptomatic. After they returned to Hawaii, he had no allergic symptoms until one night when the family drove through "sugar cane smoke" which was hovering over the highway. The patient started coughing and within one hour had developed a moderately severe asthmatic attack.

Methods and Materials

An extract of sugar cane smoke was obtained by pumping smoky air with a De Vilbiss air pump for 24 hours through a solution containing equal parts of modified Coca's solution and 99% vegetable glycerine, obtained from Colgate-Palmolive Co. This air extract was then filtered through a Seitz filter. Cultured for bacteria, it was found to be sterile.

The study group consisted of 36 patients scheduled for intracutaneous testing because of significant chronic allergy problems. These patients were tested with the sugar cane smoke extract as well as with controls of glycerine and phenol. The sugar cane smoke extract as well as the glycerine and phenol were serially diluted 1:5. Thus, the content of the glycerine and phenol in the #1 dilution of sugar cane extract was equal to the amount in the glycerine #1 and phenol #1 dilutions respectively. The #1 dilution is a 1:5 dilution of the concentrate solution, #2 dilution is 1:25, #3 dilution 1:125, etc.

Intracutaneous testing was performed using the Rinkel serial dilution skin titration method: a

Department of Allergy & Clinical Immunology
Straub Clinic & Hospital, Inc.
888 South King Street
Honolulu, Hawaii 96813

Accepted for publication July 25, 1975

4mm wheal was produced by intracutaneous injection of the test material starting with a weak dilution and progressing to stronger dilutions until a positive reaction (a wheal measuring 6mm or greater) was obtained at 10 minutes. The weakest dilution which produces a positive whealing response has been defined as an endpoint of reaction.[1]

For the purpose of this study, an intracutaneous whealing response to sugar cane smoke extract was considered to be positive if the endpoint of reaction was one dilution weaker than the endpoint of reaction for either phenol or glycerine. If, however, the endpoint of reaction to the sugar cane smoke extract and the controls were at the same dilution, then the reaction was considered negative unless the wheal measurement was at least 2mm larger for the sugar cane extract than for the control.

Results

Consecutive allergy patients were tested and a record of their exposure to sugar cane smoke was noted. The patients were then grouped according to positive and negative reactions (Tables 1 and 2). In most cases, the reaction to phenol was negative. The reaction to phenol was never greater than glycerine, therefore phenol was not included in the Tables.

Positive reactions to the sugar cane smoke extracts were obtained in 15 patients. Of these, only one person gave a history of no exposure to sugar cane smoke; most had been exposed to it frequently. Six were children, all under six years, having been exposed for less than two years. Of 17 patients who gave positive tests to sugar cane smoke, but equal to one or both controls, only four had a history of frequent exposure to sugar cane smoke. Of these, three patients gave positive reactions to the #2 dilutions of both glycerine and sugar cane smoke extract. They may have been very sensitive and reacted to both glycerine and sugar cane smoke in the extract, or may have been reacting only to the glycerine.

Statistical Analysis

These data may be analyzed statistically using the phi coefficient ($r\phi$) which is a measure of association that is appropriate when X and Y both have only two classes of observation. If one designates the X classes as X_0 and X_1 and the Y classes as Y_0 and Y_1 one may schematically represent the ordered pairs of X and Y values as shown below.

	X_0	X_1	TOTAL
Y_1	a	b	a + b
Y_0	c	d	c + d
TOTAL	a + c	b + d	n

With a table of two rows and 2 columns, a 2 × 2 table, the phi coefficient may be used as a meas-

TABLE 1. — *Group I – Positive Whealing Response to Sugar Cane Smoke Extract*

INITIAL	AGE	HISTORY	WEAKEST DILUTION GIVING POSITIVE WHEALING RESPONSE (NEG. INDICATES NO WHEALING RESPONSE) SUGAR CANE SMOKE	GLYCERINE
D.J.	4 yrs.	See case report	1:5	Neg.
K.E.	24½ yrs.	Lived on Oahu 2 yrs. at Ewa Beach. Much exposure to sugar cane smoke which she notes aggravates her nasal congestion and itchy eyes.	1:25	1:5
F.S.	8 yrs.	Lived on Kauai all of life, sugar cane fields surround their home.	1:5	Neg.
K.T.	5½ yrs.	Moved to Ewa Beach 1½ yrs. ago. Cough and rhinitis aggravated with exposure, frequent exposure.	1:125	1:5
G.T.	4 yrs.	Moved to Hawaii 1½ yrs. ago. Aggravated by sugar cane smoke.	1:5	Neg.
D.H.	1⅓ yrs.	Lives in Mililani Town, sugar smoke hovers in the valley.	1:5	Neg.
S.H.	3½ yrs.	Pt. started allergy symptoms when first moved to Mililani Town.	1:5	Neg.
D.S.	11 yrs.	Lives on Maui; sugar cane surrounds home area.	1:3125	Neg.
P.I.	20 yrs.	Exposed each yr. while on Kauai summer home, intermittent but considerable exposure.	1:5	Neg.
J.R.	3½ yrs.	Exposed on Kauai during first 2 yrs. of life. Now Hawaii Kai.	1:5	Neg.
J.S.	15 yrs.	Exposed frequently while visiting sister on weekends.	1:125	1:25
C.Y.L.	29 yrs.	Lived on Oahu all of life; intermittent exposure during childhood.	1:25	Neg.
M.K.	10 yrs.	Exposed intermittently on hikes but noted aggravation of asthma when exposed to sugar cane smoke.	1:25	Neg.
C.Y.	48 yrs.	Lived on Oahu all of life, no immediate exposure, occ. short term exposure.	1:5	Neg.
T.W.	12½ yrs.	Lived on Oahu, no exposure to sugar cane smoke.	1:5	Neg.

TABLE 2. — *Group II – Whealing Reaction to Sugar Cane Smoke Extract, Equal or Less Than Glycerine Control*

INITIAL	AGE	HISTORY	WEAKEST DILUTION GIVING POSITIVE WHEALING RESPONSE (NEG. INDICATES NO WHEALING RESPONSE) SUGAR CANE SMOKE	GLYCERINE
P.D.	12 yrs.	Lived on Oahu all of life, Pacific Palisades, some exposure.	1:25	1:25
J.A.	25 yrs.	Lives in Kailua, tour guide, drives through smoke almost daily.	1:25	1:25
R.G.	15 yrs.	Lives on Kauai. Direct frequent exposure.	1:25	1:25
D.H.	10 yrs.	First 4 yrs. on Kauai, much exposure. Since on Oahu, no exposure.	1:5	1:5
M.Y.	10 yrs.	Occasional short term exposure, Hawaii 9 yrs.	1:5	1:5
D.H.	15 yrs.	Hawaii Kai for 7 yrs. No exposure.	1:5	1:5
B.M.	4 yrs.	Pearl City, no immediate exposure.	1:5	1:5
M.L.	4½ yrs.	No	1:5	1:5
G.C.	12 yrs.	No exposure.	1:5	1:5
R.W.	15 yrs.	Kailua, no exposure.	1:5	1:5
J.A.	4 yrs.	Oahu 4 yrs. No exposure.	1:5	1:5
L.L.	19 yrs.	St. Louis Hts. 19 yrs. - No exposure.	1:25	1:25
J.D.	14 yrs.	St. Louis Hts. - No exposure.	1:5	1:5
C.W.L.	35 yrs.	6 yrs. minimal occasional exposure.	1:5	1:5
J.S.		Waialae Gardens, no exposure.	1:5	1:5
S.D.	6 yrs.	Kalihi 6 yrs. No exposure.	1:5	1:5
L.L.	11 yrs.	Lived Aiea Hts. last 3 yrs. Minimal if any exposure.	Neg.	Neg.
F.C.	12 yrs.	Kahala 3 yrs. Mainland before, no exposure.	Neg.	Neg.
S.F.	3½ yrs.	Lives near Airport 1½ yrs. No exposure.	Neg.	Neg.
M.S.	8 yrs.	Mainland until 2 yrs. No exposure in Hawaii.	Neg.	Neg.
J.G.	25 yrs.	Mainland, then Tahiti 7 yrs. No sugar cane smoke there. No exposure here.	Neg.	Neg.

ure of the degree of association between the row and column classification.

The phi coefficient is defined as follows:

$$r\phi = \frac{bc - ad}{\sqrt{(a+c)\,(b+d)\,(a+b)\,(c+d)}}$$

If one wishes to determine whether the obtained value of $r\phi$ represents a significant degree of association between the two variables, one can test the general null hypothesis to establish if the variables are independent.

The test statistic is $chi^2 = nr\phi^2$ with 1 degree of freedom (d.f.). The population studied with reference to sugar cane smoke is assigned as follows:

X_0 = population with a history of no exposure to sugar cane smoke
X_1 = population with a history of exposure to sugar cane smoke
Y_1 = population who gave positive skin test reactions
Y_0 = population with skin reactions negative (either no reaction or a reaction equal to glycerine or phenol controls)

For this study group the schematic table now is as shown below:

	X_0 = History of Neg. Exposure	X_1 = History of Pos. Exposure	TOTAL
Y_1 = positive skin test reactions	a = 1	b = 14	a+b = 15
Y_0 = negative skin test reactions	c = 16	d = 5	c+d = 21
TOTAL	a+c = 17	b+d = 19	N = 36

$$r\phi = \frac{14 \times 6 - 1 \times 5}{\sqrt{(17)\,(19)\,(15)\,(21)}}$$

$$r\phi = \frac{219}{\sqrt{101745}}$$

$$r\phi = \frac{219}{318.9 - 0.686}$$

$$chi^2\ (x^2) = Nr\phi^2$$
$$X^2 = 36\ (0.69)^2$$
$$X^2 = 17.14$$

$P < 0.01$

Thus, one can reject the null hypothesis and conclude that patients who have chronic allergic symptoms and who are exposed to sugar cane smoke give positive skin reactions more frequently than allergic patients not exposed to sugar cane smoke.

Discussion

An advantage of studying sugar cane smoke in Hawaii is that its presence is localized to small areas on the islands of Oahu, Kauai, Maui, and Hawaii. Individuals living in Honolulu are not usually exposed to this smoke.

I have made no attempt to isolate the allergenic material in sugar cane smoke. Most likely the allergen is a volatile material which evolves as a result of burning and it is soluble in Coca-glycerine solution. Urbach has reviewed the subject of volatile substances acting as allergens.[3]

Patients who noted aggravation of their allergic symptoms when exposed to sugar cane smoke consistently gave positive wheeling reactions. However, other allergic patients who were exposed frequently to sugar cane smoke and who had positive intracutaneous wheeling reactions to it had not observed that exposure to the sugar cane smoke provoked their allergic symptoms. Allergic patients are commonly unaware of which allergens produce their symptoms.

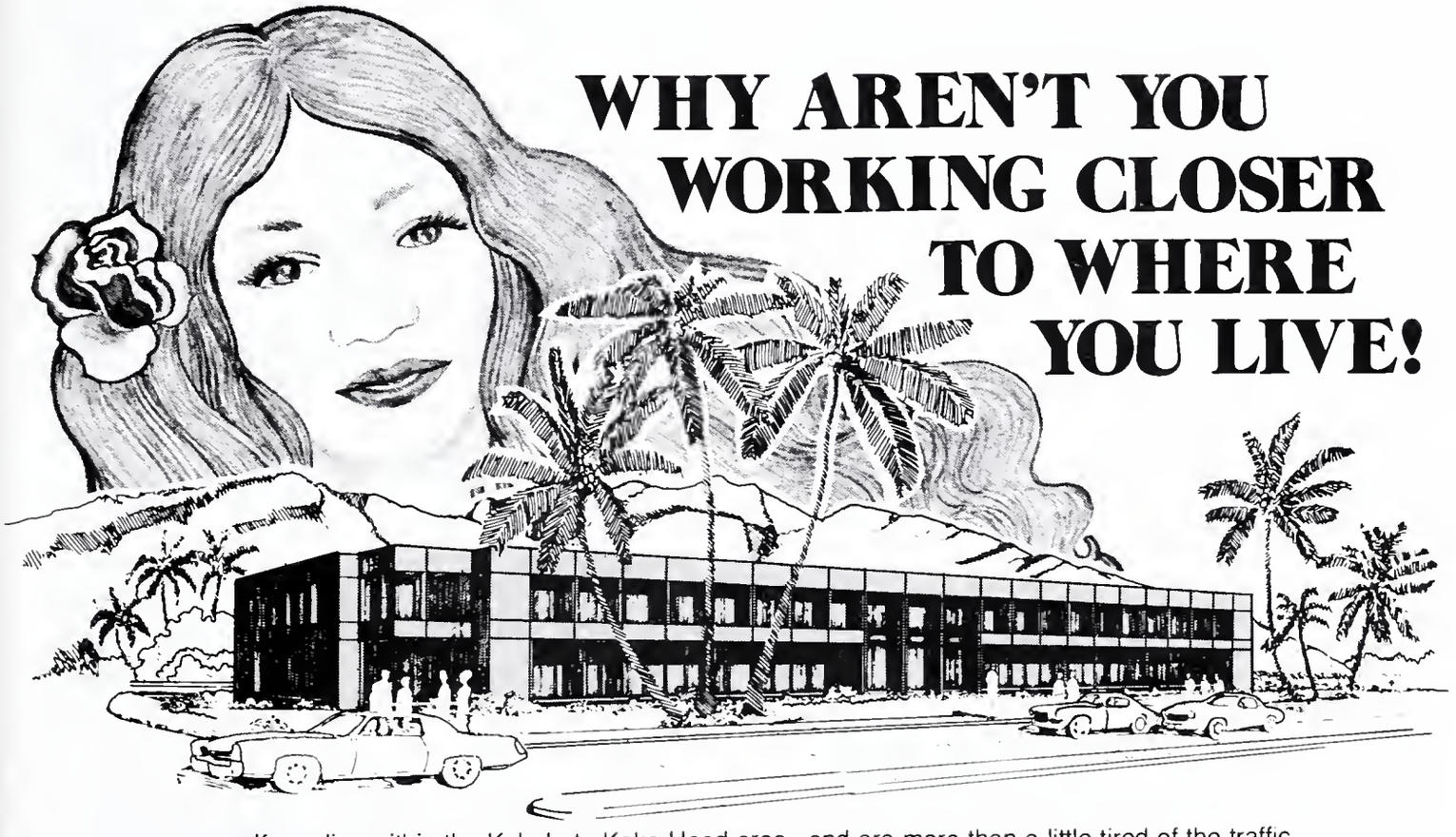
This study demonstrates a method of extracting material from the air by use of an air pump. This method may be helpful in a nonspecific way to establish if allergenic material is present in the air under various environmental conditions. One may assume that a patient who is allergic to a substance in the air may give a positive intracutaneous wheeling response which is more sensitive in detecting a small amount of a pollutant in the air than is possible by use of present biochemical assays.

When a patient is aware that his allergic symptoms are worse in an environment in which he cannot avoid, eg his work environment, an air extract from that specific environment might be made and used in hyposensitization therapy even though a specific allergen cannot be identified.

Specifically, this study suggests that sugar cane smoke may induce allergic symptoms in susceptible individuals. Continued control of burning sugar cane only under certain climactic conditions is suggested. Altered methods of harvesting sugar cane without burning are suggested when such methods become available and economically feasible for the cane sugar industry.

REFERENCES

1. Rinkel J: The Preparation of Solutions, the Making of Dilutions, and Syringe Technique. *Arch Otolaryngology* 77:64-77, January, 1963.
2. Edwards, AL: Statistical Analysis, Third Edition, Holt, Rhinehart and Winston, Inc.
3. Urbach, E: Odors (Osmyls) As Allergenic Agents. *J Allergy* 13:387-396, 1942.



If you live within the Kahala to Koko Head area, and are more than a little tired of the traffic, it just might be time to look into the Aina Haina Professional Building.
It really is a lovely building and of course the location alone may be the best feature to you.
Areas from 300 to 6,000 square feet are available with some very enticing leasing arrangements.
For information on how you can work closer to where you live, call:

AINA HAINA PROFESSIONAL BUILDING - 524-2023



H. Tom Thorson

HMA Annual Meeting Items of interest to members:

Dr. Calvin Sia was installed as the new president; Dr. Marion Hanlon of Maui was elected president-elect; Dr. Douglas Bell, II the new Secretary, and Dr. Grover Batten remains as Treasurer for 1977.

Tom Thorson was honored in various ways upon his retirement as the Executive Director of HMA. Everyone wished him well.

The budget adopted for 1977 exceeded, for the first time, the one-half million dollar mark.

The HMA concerns over the Cancer Center of Hawaii activities in the clinical areas provided much debate. The House of Delegates supports the Cancer Center's activities dealing only with basic research, epidemiology, cancer control, and clinical investigation. Where no agreement can be reached on problem areas, these areas are to be brought before the Cancer Center Executive Committee and the HMA is to continue to work with the Cancer Center Executive Committee and the Administration to resolve such problems.

House approved the concept that a child's physician be included in evaluation and follow-up care of the child with learning problems which is necessary for total care of the child.

House re-affirmed support of Tel-Med operation.

House adopted resolution which directs HMA to explore the feasibility of HMA continuing the coordination, development, and administration of the comprehensive training and educational programs of the HMA-EMS program in Hawaii.

The House, noting that the Federal Trade Commission is investigating the use of relative value studies across the nation relating to possible violations of the Sherman Anti-trust Act, received the report of the Fee Survey Committee to publish a 1977 edition of the Hawaii RVS and referred it to the officers and HMA Council for study and appropriate action.

The House adopted nine recommendations of the ad hoc committee on medical malpractice including instructing HMA to pursue changes in the legal doctrines section of the malpractice law, opposing the section of the law requiring insurance for licensure, and HMA pursuing the study of the formation of a self-insurance company.

The House, recognizing that it has recommended increments in dues in the past in line with the cost of living, has determined that the HMA dues will remain at the same level for 1977. A full record of the entire proceedings of the House of Delegates will be published in the December issue of the **JOURNAL.**

AMA Clinical Session, December 5-9, 1976, Philadelphia, Pennsylvania. Registration for sessions in JAMA.

Chief, Children's Health Services, DOH, has issued maximum conversion factors, effective September 5, 1976: Anesthesia—$10.50; Surgery—$10.50; Diagnostic Radiology (includes Radiation Therapy & Nuclear Medicine)—$2.40; Medicine (includes additional for report)—$.90; Pathology—$.30. Any questions or details, call DOH, phone 548-6500.

AMA Notes that Malpractice Research, Inc., of Herndon, Virginia, advertises that it will have a patient's medical records reviewed to evaluate any possible areas of medical malpractice for a fee, depending upon the type of evaluation desired. April 5, 1976, issue of Washington Post newspaper states that Virginia Attorney General is investigating this firm.

The Grace Bryan Taylor Fund is available to help defray the medical expenses of individuals who are suffering from angina pectoris. For further information, call Hawaiian Trust Company, Ltd., phone 525-6512.

The Medical College of Pennsylvania and Hospital embarking on a two-year oral history project dealing with women in medicine. Material gathered will be housed in Medical College of Pennsylvania Special Collection on Women in Medicine. Project wants to do in-depth interviews of fifty women physicians. Interested women physicians please contact the HMA office.

Needed on Kauai is a Japanese-speaking family physician to take over for Dr. Clyde H. Ishii of Lihue who is retiring on January 31, 1977. Further information by calling 245-2121 on Kauai.

Parting Shot from Tom Thorson: The recent election produced some disappointments but no real surprises. It brings to mind a statement once made by Frank Herbert: "Good government never depends upon laws, but upon the personal qualities of those who govern. The machinery of government is always subordinate to the will of those who administer that machinery. The most important element of government, therefor, is the method of choosing leaders."

It pays dividends at times to "throw the rascals out" because inevitably government tends to act exclusively in the interests of the ruling group—whether that group be hereditary royalty, oligarchs of financial empires, or entrenched bureaucracy. Let us hope that we have chosen wisely for the future.

American Association of Medical Assistants, State of Hawaii, needs the support of physicians in furthering its aims to provide excellence of office personnel in physicians' offices. There are some 200 to 400 thousand such medical personnel across the nation and, as such, provides much of the contact between patients and the doctor. You, the physician, need to be aware of the AAMA and what it is trying to do for YOUR office people. Please encourage and support your office personnel in their activities with the AAMA.



Aloha No, Tom Thorson!

Harvey Tom Thorson was born August 26, 1912, in Meckling, South Dakota. After a year in the South Dakota School of Mines and another in the University of Missouri, he received a bachelor's degree in 1934 from the University of Alabama in journalism, sociology, and mathematics—and he's been using these talents in his business ever since.

He married Ethel Viehmeyer the same year he graduated from college, and they have had two daughters Becky and Cathy, both married.

After four short and obviously instructive tours of duty in government service—Federal Transient Service, U.S. Treasury Accounts Office, Public Welfare in Ellensburg, Washington, and U.S. Engineers in Alaska—he found his real life work as executive secretary of the Okanogan County Medical Society, in 1946, a job he kept at for 17 years, until 1963.

He was president of the Kiwanis there in 1950; president of the Okanogan Chamber of Commerce in 1953; a member of the Washington State Advisory Committee on Medical Care in 1957; and president of the Okanogan School Board in 1960. In 1963, Tom became executive secretary of the Honolulu County Medical Society. He became executive director of the Hawaii Medical Association as well in 1971 on the retirement of Lee McCaslin.

Tom Thorson has been a powerful force for good in our medical society and association and in the community. He has moved with the medical society leaders, not independently of them. He built an effective administrative staff, and brought along a competent younger associate against the day of his retirement. He has been a fine, effective lobbyist, and it is through no fault of his that perhaps his most important and final legislative effort, the Malpractice Act, came out in the form it did, as a result of the activities of a few legislators who were blind to their conflict of interest as trial attorneys.

Tom Thorson has been through some very trying times and has managed these times most admirably. His retirement will take him away from such times for a "better life" in Sequim, Washington. Tom's accomplishments are well known. We can only now wish him Aloha and God speed.

H.L.A.

As the English have it

The Royal Academy of General Practitioners of England invited the AAFP to hold its Invitational Scientific Congress in London immediately after its Boston annual meeting late in September. Included in the program were two solid mornings of discussion on the National Health Service (NHS) and how it was working. The speakers also made some comparisons with the American system of medical care.

Besides the delightful atmosphere of London in the autumn, the traditional plush decor of the ballroom of the Grosvenor House Hotel on the edge of Hyde Park, the faultless P-A system with no visible obstructing microphone, and the beautiful sound of grammatically correct and fluent language, the two mornings gave us American family physicians a fascinating glimpse into a medical system totally different from our own.

There are many aspects of a comparison between "theirs" and "ours" that should be of great

interest to, and should be shared with, the faithful readers of this JOURNAL.

Because of its immediate pertinency, the subject of the conference first to be reviewed here is Medical Practice Liability.

Speaker Michael Freeman, Orthopaedic Surgeon at the London Hospital, said the English physician now pays the equivalent of $70 a year for protection. This is up a bit from previous years. He compared that figure with the $40,000 his orthopedic counterpart in New York or California has to pay annually. "The difference primarily lies in social custom", he said.

Program moderator Dr. Stuart Carne, who practices as a GP two and a half miles out of the center of London together with four other GP's in a group, stated that in England there is a complaints mechanism within the NHS. Each Area has a committee made up of three GP's, three lay people, and a chairman, which resolves the complaints put to it. The one great factor in keeping the cost of the proceedings of these committees down is that no legal counsel is permitted to be present, and these complaints are not allowed into the courts initially.

Michael Fairey, the Administrator of the Northeast Thames Regional Hospital Board, pointed out that "it was NOT the custom in England to sue your doctor." He felt the grievance mechanism worked quite well and that the plaintiff/patient was reasonably satisfied with the Area Committee's determinations. The rate of actual suit in court against a GP was only one in 50 years; NO hospital consultant had ever been sued, according to Orthopaedist Freeman!

It was obvious that the fund into which each English physician paid $70 annually was probably more than adequate to cover actual damages to the rare patient for which the Committees felt the particular physicians were liable. There were no attorney's fees nor court costs involved in an all-important first level of review!

Speaker Sir George Godber, former Chief Medical Officer of the British Department of Health, added that the referral system from GP to Consultant probably also contributed to the paucity of claims of malpractice.

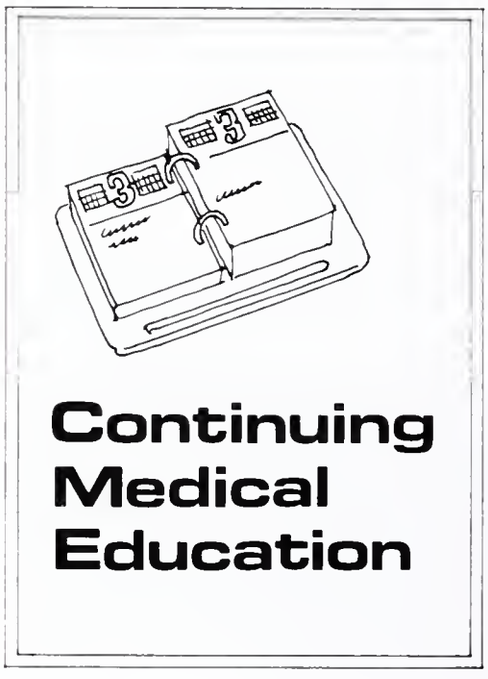
Dr. Carne had served for some time on such a "Concilliation Panel," as we call it here in Hawaii, and it was his opinion that the patient was very well treated. "There were an infinitesimally small number of complaints," he was proud to say, "against general practitioners."

Through an interesting coincidence, a London newspaper that very morning reported new legislation proposed in the Parliament, to allow entry of legal counsel early within the medical grievance system. The speakers were all aware of this, and Godber said the measure would be strongly resisted. Fairey, however, thought it made common sense, and that communication between America and England was such that the American lawyers' influence would prevail!

The "contingency fee" is not allowed under English law.

More later

J.I.F.R.



CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m.

John A. Burns School of Medicine

1. University Grand Rounds in Psychiatry, Tuesdays, 10:00-11:30 a.m. at Queen's or St. Francis. (Contact John F. McDermott, Jr., M.D. or Wen-Shing Tseng, M.D. for further info)
2. UH Medical Grand Rounds, Tuesday (1st & 2nd) 12:30-1:30 p.m., Mabel Smyth Bldg. 1¼ hr. credit, Cat. 1

Kaiser Hospital

(Contact CME Dept. for further information)

Kauikeolani Children's Hospital

1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program

Kapiolani Maternity Hospital

1. Grand Rounds, Wednesdays, 7:30-8:30 a.m.
2. Resident Conference, Tuesdays (except 1st), 1:00 p.m.
3. Ob-Gyn Department Meeting, 1st Tuesday, 1:00 p.m.
4. UH Seminars, Wednesdays, 3:30 p.m.
5. Perinatal Conference, Thursdays, 3:30 p.m.
6. Tumor Board, 1st & 3rd Fridays, 1:00 p.m.
7. Oncology Conference, 4th Friday, 1:00 p.m.
8. Visiting Professor Program

Kuakini Hospital

(Contact CME Dept. for further information)

The Queen's Medical Center

1. Medical Grand Rounds, Every Friday, 8:00 a.m., Kam Auditorium
2. Surgical Conferences, 1st Tuesday, 4:30 p.m., Kam Auditorium
 Medical-Surgical Conferences, 2nd Tuesday, 4:30 p.m., Kam Auditorium
 Surgical CPC, 3rd Tuesday, 4:30 p.m., Kam Auditorium
 Basic Science Lectures, Every Wednesday 7:15 a.m., Surgical Conference Room
3. Ob/Gyn Conferences, 2nd and 4th Mondays, 12:30 p.m., Blood Bank Conference Room
4. Pathology Conferences, Every Wednesday, 7:30 a.m., Blood Bank Conference Room
5. Pediatric Grand Rounds, 2nd Wednesdays, 12:30 p.m., Harkness 128
6. Orthopedics Conferences, Every Friday (except the last), 7:30 a.m., Blood Bank Conference Room
7. Tumor Conferences, Last Tuesday, 7:30 a.m., Kam Auditorium
8. Urology Grand Rounds, as designated
9. Psychiatry CME Conference, as designated
10. Neurology/Neurosurgery Conference, as designated

Hickam Clinic

1. Clinical Correlation Conference, 1st Thursday, 11:00 a.m.
2. Didactic—our staff, 2nd Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, 3rd Thursday, 11:00 a.m.
4. Radiology Conference, 4th Thursday, 11:00 a.m. (Contact H.P. Stern, Capt, M.D., MC at 449-9742)

St. Francis Hospital

1. Medical Grand Rounds, Tuesday (4th & 5th) 12:30-1:30 p.m. Sull. IV Classroom
2. Surgical Grand Rounds, Fridays (except 4th) 7:30-8:30 a.m.
3. Tumor Conference, Mondays, 7:30-8:30 a.m.
4. Visiting Professor Program
5. EENT Teaching Rounds, Tuesday (1st) 7:00 a.m.
6. Psychiatry for the Non-Psychiatrist, Tuesdays (2nd) 12:00-1:00 p.m.
7. Surgical Mortality & Morbidity Conference, last Friday, 7:30-8:30 a.m.
8. Saturday Teaching Rounds, Saturdays (except 4th) 7:30-8:30 a.m.

Straub Clinic & Hospital

1. Medical Grand Rounds, first Thursday, 7:00 a.m.
2. Surgical Mortality & Morbidity, 4th Thursday, 7:00 a.m.
3. Quarterly Professional Staff Meetings, (Jan., Apr., Aug., Nov.), 4th Monday, 7:30 p.m.

Wahiawa General Hospital

1. Noon Seminars, 2nd Friday & 4th Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:30 p.m. & 2nd Wednesday, 12:30 p.m. of each month in the 320 Ward Ave. Building. Contact HMA Office as dates are subject to change.

Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817
At: Honolulu County Medical Society and Local Hospitals, Honolulu
Type: I, 1 hr/day, 1 day/mo from 12 mos
Fee: None Methods: AV, O, Pan
Dates: All yr, 12 hrs instruction

Telephone Task Force—Hawaii (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817
Type: I, 1 hr/day, 1 day/mo for 8 mos
Fee: None Methods: AV, Clin C, O, Pan, R
Dates: Arranged; 8 hrs instruction

SPECIAL EVENTS

Nov. 17-24, 1976 & March 13-19, 1977	Diving Medicine (B-50) Undersea Med. Soc., c/o Professor Edward Beckman, University of Hawaii Conference Center, 1960 East-West Road, Honolulu, 96822 At: Kailua Kona Type: C, 8 days Fee: $200 Methods: AV, OP, PP, Lec, O, Sem 25 hrs instruction
Nov. 27	"Hyperlipidemia," A.G. Scottolini, M.D. & N. Bhagavan, PH.D.-Kaiser Pac. Aud. Kaiser Hsp. 7:30 a.m. 1 hr. credit-Cat. 1. Contact: Medical Staff Secretaries.
Dec. 4	"Acute Surgical Abdomen-Part I—Clinical Diagnosis of Small Bowel Obstructions"-Jeffrey Millman, M.D. 7:30 a.m.-Kaiser Pac. Aud.-Kaiser Hsp. 1 hr.-Cat. 1. Contact: Medical Staff Secretaries.
Dec. 11	"Intersex"-Frank E. Ceccarelli, M.D.-7:30 a.m.-Kaiser Pac. Aud.-Kaiser Hsp. 1 hr.-Cat. 1. Contact: Medical Staff Secretaries.
Dec. 18	"Acute Surgical Abdomen-Part II—Clinical Diagnosis of Acute Appendicitis"-Clifford J. Straehley, M.D. 7:30 a.m.-Kaiser Pac. Aud.-Kaiser Hsp. 1 hr.-Cat. 1. Contact: Medical Staff Secretaries.
Jan. 17-20, 1977	"Ischemic Heart Disease, Problems & Perspectives", Royal Lahaina Hotel, Maui, HI. Cat. 1—13 hrs. credit. Contact: Mr. Harold Brown, phone 373-3045.
Jan. 18-24, 1977	Hawaii Hsp. Medical Staff Conf. (B-350) Estes Park Inst., Box 400, Englewood, CO 80110. 6 days, Fee $175, 30 hrs. To be held at Kauai Surf Resort, Kalapaki Beach, Kauai.
Jan 23, 1977	Cancer in the Aged (B-100). Straub Clinic & Hsp. 888 So. King St., Hono, 96813. Co-Sponsor: American Geriatrics Society. 1 day-6 hrs. Fee $40.
Jan. 24-28, 1977	Advanced Techniques & Complications of Total Joint Replacement. Joint Implant Surg. & Research Foundation, 1300 N. Vermont Ave. S 601-Los Ang. 90027 for contact. Held: Kona Hilton, Kona. Fee $350.
Jan. 25-27, 1977	Hawaii Post-Conf. Workshops-Maui Surf Resort, Kaanapali Beach, Maui. Fee: $100. Contact: Estes Park Institute, Box 400, Englewood, CO 80110.
Jan. 31-Feb. 5, 1977	Prenatal Med.-Royal Lahaina Htl.-Maui. Contact: Univ. of Southern Cal. Sch. of Med, 2025 Zonal Ave. LA 90033.

The seminars on "Sexual Counseling: Office Management of Sexual Problems" sponsored by the ACOG and University of Hawaii will be held on the following dates: (20 hrs. credit)

October 18-22 December 20-24
November 22-26

For further information, write to: American College of Obstetricians & Gynecologists, Department of Continuing Education, 1.E. Wacker Drive, Suite 2700, Chicago, IL 60601

Hawaii Academy of Family Physicians' Newsletter

J.I. Frederick Reppun, M.D.

New Members—We welcome aboard Student members **Kathleen Ackerman,** UHSM '77, **John P. Grabbe** '80, **Stephen K. Miyasato** '80, **Richard A. Pekala** '79, **Kenneth Francis Perske Jr.** '80 (he is LtCol USAF Ret.) and **Norman G. White** '79.

News of Members—Barbara Thomas also attended the 28th Annual Scientific Assembly in Boston, but she is being dropped from our rolls for failure to qualify for Active membership after being an Associate member for several years. **Juan Tomas Van Putten MD** is back and in practice in Mililani Town. **Gerald Yorioka** is in Greenbank, Washington. **Capt W. Gordon Podolsky,** MC USNR is now an Active member rather than Associate.

HAFP Constitution & By-Laws—will be updated and available for perusal by members who care to do so at the HMA office, 320 Ward Ave. by the end of the year. They must be voted on at our annual meeting late in January 1977. Council has already taken action on making Osteopaths eligible for membership and at the annual meeting members will be asked to approve this action. Notice has been mailed to all members 24 October, at least 90 days prior to the annual meeting.

Special—Don't forget the Sports Medicine for Primary Physicians at the PK in Waikiki 8 to 12 March 1977 sponsored by the UH. Those interested should apply to Richard Strauss, Dept. Physiology, Bio-Med Science Building T-608, East-West Road, Honolulu 96822.

Rural Health—The AMA's 30th Nat'l Conference on Rural Health will be held 30 March - 1 April 1977 at the Washington Plaza in Seattle.

G.A.F.P.—The Georgia AFP is offering a "mini" correspondence course on "Primary Care for the Newborn" good for 30 hours "P" beginning 18 April. Final enrollment deadline is 18 February and the cost is $130 to members AAFP. Anyone interested, please contact our Exec. Sec. Jean Reppun.

Hawaii Medical Ass'n—at its recent annual meeting retired **R. Varian Sloan** who has served as Secretary of the State association for 10½ years. The new HMA Council will have only two members of HAFP: **Verne Adams** of Hawaii County, Councillor, and **Fred Reppun,** Honolulu Councillor. **John Budd,** AAFP, the President-elect of the AMA gave an address to the HMA House of Delegates and installed the new officers at the annual banquet.

Alaska—has a new Medical Liability Law and they too **must** buy insurance. However, the Family Physicians have an added problem: The premiums are based on a percentage of *gross* income; their overhead is a great deal higher than that of surgeons, for example. FP's are very resentful!

HMA Council Meeting

Friday, September 10, 1976, 5:30 p.m.
320 Ward Avenue

CALL TO ORDER

The first Council meeting to be held in the new HMA headquarters at 320 Ward Avenue was called to order by President William W.L. Dang. Also present were Drs. Winfred Lee, Calvin Sia, R. Varian Sloan, Grover H. Batten, Herbert Chinn, Ann Catts, Albert Chun-Hoon, Rowlin Lichter, Carl Lum, J.I.F. Reppun, Arnold Siemsen, Sakae Uehara, Verne Adams, Peter Kim, Douglas Bell II, and Clifford Moran. Dr. Clarence Funaki was seated for Dr. Thatcher Magoun, Dr. William Moore, Jr. was seated for Dr. John Kim, and Dr. Roy Kuboyama was seated for Dr. George Goto. Also present were Dr. Alan Pavel and Mr. Thomas Rice.

MINUTES

The minutes of the July 30, 1976 meeting were approved as corrected.

TREASURER

The July 1976 financial statement was circulated.

ACTION:

A motion was made and seconded to accept the July 1976 financial statement subject to audit. The motion passed.

REPORTS OF THE COMMITTEES AND COMMISSIONS

A. EMS: Dr. Sia reported that there have been several meetings regarding the EMS program and noted that the role of the HMA will be primarily in training and education. A copy of a letter from Dr. Sims regarding his evaluation of an emergency medical card was circulated. There were questions regarding the update of information on the card and whether the EMS Board had reviewed the specifications of the card.

ACTION:

A motion was made and seconded to postpone action and refer the card to the EMS Board for their review. The motion passed.

B. Mutual Insurance Company: Dr. Pavel reported that the HMA/HHA committee appointed to investigate the feasibility of forming a self-insurance company has been reactivated. He noted that plans for forming a company were held in abeyance in early 1976 primarily because it was almost impossible to obtain reinsurance above the $100,000 level and it was thought that the new legislation would solve many of the problems associated with the availability of medical malpractice insurance. Dr. Pavel noted that aside from the mandatory requirement for professional liability insurance for licensure provided by Act 219, the new law governing medical practice and professional liability insurance has many good points: the new Patients' Compensation Fund eliminates the need for reinsurance over $100,000 and losses should be controlled with the institution of the patients' conciliation panels and the strengthening of the Board of Medical Examiners. He noted that there is still the problem of obtaining reasonable insurance in Hawaii and urged the Council to consider the formation of a self-insurance company which could possibly reduce premiums by keeping losses down and keeping administrative costs to a minimum. He noted that Frank B. Hall & Company, who prepared the original feasibility study, has indicated their willingness to prepare a proposal for a mutual insurance company for submission to the Insurance Commissioner of the State of Hawaii. He asked the Council to approve an appropriation for the preparation of a self-insurance proposal. The Hospital Association will be asked to share one-half of the expense involved. If the insurance commissioner accepts the proposal, it would be up to the House of Delegates whether or not the association would enter into a self-insurance business.

ACTION:

It was moved and seconded and voted to approve an appropriation of up to $5,000 for the preparation of a proposal that may or may not be accepted by the insurance commissioner for a self insurance program, with or without the Hospital Association.

C. Malpractice Insurance: Mr. Thorson reviewed the



THE FINAL STEP TO THE TOP!

The last of its kind in this area . . . Overlooking Waialae Country Club is a lifestyle that's second to none in custom built homes. Heights of luxury living unfold into a spectacular panorama from Diamond Head to Koko Head . . . sunrise to sunset. Your home design or ours, or a combination of ideas . . . our architects will work with you in this very special exclusive area.

From **$163,400**
55 year lease
Model home open 7 days a week
Weekends 10 AM to 5 PM
Weekdays 1 to 5 PM



WAIALAE IKI IV

Herbert K. Horita Realty, Inc. Kalihi Phone: 847-4241/Waimalu Phone: 487-1561/Waikiki Phone: 922-3377

present malpractice insurance situation with regard to physicians who decide to drop their professional liability insurance. Mr. Rice reported that his researchers have begun the initial phases of preparing a suit to contest the mandatory insurance provisions of Act 219. He reported that researchers have found no cases that would support the unconstitutionality of Act 219 and noted that at no time has the U. S. Supreme Court stated that it is a constitutional right to earn a living. At a meeting of the special ad hoc malpractice advisory committee, it was recommended that HMA attorneys proceed with their investigation. He noted that the cost of filing a suit might run between $25,000 and $100,000. It was recommended that the Council authorize a membership assessment of $25 per member for court costs and that the House of Delegates be asked to approve a higher amount for the continuation of the research for the suit. It was also recommended that because of the limitation on assessments which can be approved by Council and with the imminence of the House of Delegates meeting that the Council defer action to the House.

ACTION:

It was moved, seconded and passed that the question of an assessment for court costs for contesting the mandatory insurance provisions of Act 219 be referred to the House of Delegates and that the membership be contacted by letter asking if the members would be willing to contribute to such a fund based on the information available and the potential cost of a suit.

D. Convention Committee: Dr. Sloan reported that plans for the annual meeting scheduled for October 24-29 are running smoothly. He noted that several of the sport events are underway.

E. Cancer Center: Dr. Chinn presented a synopsis of activities of the Cancer Center activities over the past year. He noted that the Community Based Cancer Program is being reviewed by the HMA Cancer Committee and Cancer Commission and they will meet with Dr. Piette in the near future to discuss the protocol.

F. Mabel Smyth Board: Mr. Thorson reviewed negotiations presently underway with regard to the occupancy of the former HMA quarters in the Mabel Smyth Building. The question presently rests with the Mabel Smyth Board of Directors.

G. Ad Hoc Building Committee: A budget recap was presented to the Council. It was noted that the Hawaii Tumor Registry will move into their new quarters at 320 Ward Avenue on October 1. It was noted that the move into new quarters went smoothly and that the delivery of conference furniture is expected in October.

ACTION:

It was moved and seconded to commend Andy Saranchock and Becky Kendro for coordination of the move to 320 Ward.

H. Common Fund Committee: Mr. Won reported that a meeting of the Common Fund Executive Committee composed of HMA president and treasurer and HCMS president and treasurer was held immediately prior to the Council meeting. HCMS has requested to enter into a contract arrangement with the HMA rather than continue the Common Fund. It is recommended that annual contract be negotiated based on the staff time studies done each year.

ACTION:

It was moved, seconded, and passed that approval be given for the HCMS to enter into a contract with the HMA for services on an annual basis and that the contract be negotiated on staff time studies.

Dr. Dang reported that the Building Committee also met prior to the Council meeting and discussed the present lease agreements at 320 Ward Avenue.

ACTION:

It was moved, seconded, and passed that the Building Committee be given the responsibility of renegotiating any and all leases that are pertinent to the maintenance of the building.

I. Commission on Public Health: Dr. Kuboyama presented a resolution on swine flu that was adopted by the Communicable Disease Committee on August 9, 1976.

ACTION:

It was moved, seconded and passed to modify the resolution to read as follows:

WHEREAS, there has been no further confirmed clinical outbreak of the "swine flu" due to influenza A/New Jersey since the original report from Fort Dix, and

WHEREAS, there is no unanimous opinion regarding the value of a mass immunization program against swine flu, and

WHEREAS, there is reported 2 to 3% side effects from the influenza A/New Jersey vaccine in vaccinees 18 years of age and older and a higher rate of morbidity in those under 18 years of age, and

WHEREAS, there is involvement of considerable expense and utilization of man power in a mass immunization program, and

Is the diagnosis ALCOHOLISM?

Time proven alcoholism treatment — formerly available only at Mainland centers — now offered at Post Hospital Recovery Unit, Hilo Care Center.

- A basic, 28-day in-patient program of motivational counseling
- Therapists carefully selected and themselves recovered alcoholics
- Hawaii licensed professional consulting staff in psychiatry, psychology and family medicine
- Privacy, seclusion, total confidentiality in modern facility, beautiful setting

Direct inquiries to:
Marilee Fletcher, Associate Director,
Post Hospital Recovery Unit,
HILO CARE CENTER
944 West Kawailani Street
Hilo, Hawaii 96720 Phone (Hilo) 959-9151

WHEREAS, the private physicians do administer flu vaccines to their high risk group and do plan to use the swine flu vaccine, now therefore be it

Resolved, that the Hawaii Medical Association

(a) Commend the Department of Health for alerting the medical profession and lay public of a possible outbreak of a new strain of flu virus (A/New Jersey) and also commend the Department of Health for their vigilant surveillance to detect swine flu;

(b) Recommend that physicians be urged to administer the appropriate flu vaccine to the high risk group;

(c) Recommend that the Department of Health carry out necessary immunization of the population and that each physician recommend from the facts available whether or not his patient receive the swine flu vaccine and furthermore that the patients be informed that the immunization being given is against swine flu only and does not give protection against the A/Victoria or Hong Kong flu virus.

(d) Support the concept that the DOH continue its open relationship and communications with the HMA on the latest development of the swine flu program.

RETIREMENT PLAN

A corporate resolution was adopted authorizing the Secretary and President to sign a trust agreement for the HMA retirement plan.

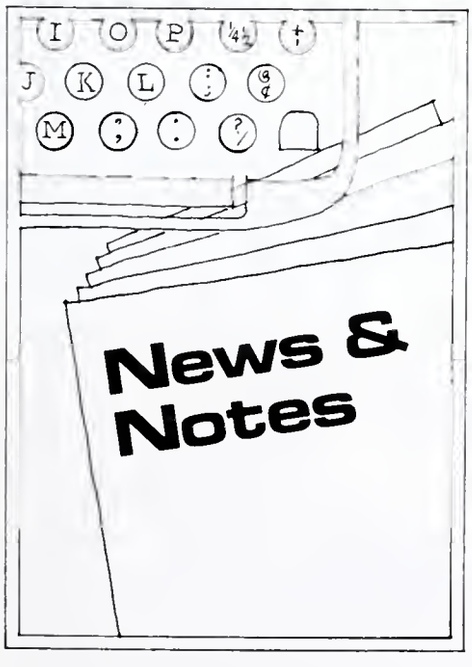
NEW BUSINESS

Dr. Dang announced that the next Council meeting was scheduled for October 1 and that discussion would be limited to the 1977 budget unless there were items of an emergency nature.

ADJOURNMENT

The meeting adjourned at 11:00 p.m.

R. VARIAN SLOAN, M.D.,
Secretary



HENRY N. YOKOYAMA, M.D.

Tom Thorson's Corner

L.M. former governor of Georgia and avowed segregationist was feeling a might poorly and went for a checkup . . . The doctor, after examining and reviewing the lab results, said gravely: "I have good news and bad news." L.M. said apprehensively: "Doc, let's have the good news first." "Well, you have prostate cancer which has spread everywhere." "That's the good news?" L.M. asked incredulously, "Then, what's the bad news?" "You have sickle cell anemia," was the reply . . .

John and Chris were identical twins . . . John went on to become a minister and Chris a doctor . . . They both returned to their hometown . . . One day, an old timer stopped Chris and asked, "Are you the twin that preaches?" "No," replied Chris, "I'm the twin that practices."

Professional Moves

We are still catching up with announcements we had missed. Back in June, OB man **Elbert Tomai** joined **Satoru Nishijima** at 1024 Piikoi St. In July, eye man **Robert Young** joined the Kona Coast Medical Group at 207 Hamilton Bldg., Kailua, Kona.

Along came August: Pediatricians **Stephen Temby** and **Wayne McKinny** opened a branch office in Ken's Bakery, 41-865 A Kalanianaole Hwy., Waimanalo . . . Child psychiatrist **Peter In** opened his office on the Honokaa Hospital grounds . . . GP **Michael Hase** opened at the Kahala Professional Bldg., 4747 Kilauea Ave. . . . The Hawaii Permanente Group added surgeons **James Crowley** and **Chester Poole** and OB man **Rodney Francis** . . . Eye man **Dennis Maehara** relocated to the Medical Arts Bldg., Suite 701 . . . OB man **Ronald Berman** joined **Murray Berger** and **Neal Winn** at 1040 So. King St., Suite 312 . . . Gastroenterologist **Gerald Hiatt** joined the Fronk Clinic . . . OB man **Chao Chen** opened at the Alexander Young Bldg., Suite 357 . . . On the Big Island, surgeon **Minolu Cheng** relocated to the Kuakini Professional Plaza in Kona . . . Poor **Timothy Wee.** He wanted to retire so he placed an announcement in the papers, but the ad read "Dr. Timothy Woo" (Perhaps the typesetting gremlins are *woo*ing him to remain in practice).

In September, the dam finally broke and the deluge was upon us: Gastroenterologist **Myron Lezak** and cardiologist **Masahiro Mori** joined the Hawaii Permanente Group . . . OB men **Noboru Ogami** and **K.S. Tom** relocated to Kapiolani Hospital as the Ob-GYN Associates, Inc. . . . Dermatologist **Bruce Chrisman** joined the Honolulu Medical Group . . . Surgeon **Jose Madamba** associated with the Varsity Medical Clinic . . .

Strange announcements emanate from the outer islands . . . **Tadao Nagashima** MD Inc. of Hilo announced that effective Sept. 1, he was not accepting any cases involving plastic surgery, neurosurgery or traumatic surgery . . . In Kona, **Thomas Mar** who had practiced 21 years announced that the new malpractice law was forcing him to retire . . . A **Terrence Young** who joined the Kona Medical Associates took over the practice . . . ENT man **Chalmers Hamasaki** opened his office at Ka Waena Lapa'au, Hilo . . . On Kauai, Surgeon "Dr. **Thatcher Magoun,** M.D." joined the Kauai Medical Group . . . On Maui, internist **Michael Richard Savona** joined the Maui Medical Group . . .

Physician Heal Thyself . . .

Psychiatrist Thomas Bittker of Phoenix, Arizona, reported in JAMA that physicians who build successful

careers by working 60 and 70 hours a week may be leaving themselves open for depression and suicidal tendencies . . . The problem is further complicated because physicians hesitate to seek help from psychiatric colleagues . . . He further warns that alcoholism, drug abuse and suicide may be the end result since self sacrifice, perseverence, competitiveness, and denial of feelings are essential for matriculation of med student into the mature professional . . . Bittker cites that 5 to 6% of the nations' doctors (17,000) are victims of alcoholism, drug abuse or mental illness . . . The suicide rate of white male physicians under 40 is 4 times higher than in other professions and ½ of the physicians have unsatisfactory marriages . . . Bittker suggests that the problem can be prevented by teaching med students to lead more balanced life styles than the 70 hour work week their med school profs are living . . .

Elected, Appointed, & Honored

Mark Sowers was one of three honorees at the Mental Health Association's Maui branch annual awards ceremony in Kihei. Mark, current Maui president of MHA was recognized for his active role since 1959 with the Mental Health Council, with drug abuse projects and with the "Help Line," a crisis telephone service . . .

Hilo cardiologist **Jiro Nakano** was invited to lecture on "Prostaglandins in Clinical Medicine" at the Denison Memorial Hospital in Dallas, Texas for their 1976 Blackford Memorial lectures . . . Jiro was professor of Medicine and Pharmacology at the U of Oklahoma College of Medicine where he did prostaglandin research from 1965 to 1974 and has over 100 published papers and 5 books on prostaglandins . . .

William Holmes was recently elected president of the Asia-Pacific Academy of Ophthalmology . . . The Big Island Unit of the Hawaii Heart Association awarded outstanding achievement plaques to **Richard Lundborg** and **DeWitt Hendee Smith.** Speakers at their annual meeting included cardiologists **A. Scott Miles, Jiro Nakano** and **Djon Indra . . .**

Sportsmen

Of Fishermen: Each year 'round the 4th of July weekend, **Tom Frissel** calls us to pick up sashimi and once again Tom did not fail . . . The physician trio of Tom, **Ted Tseu,** and **Roy Kaye** went on their annual 3 day fishing trip off Niihau with happy results . . . Roy latched onto a 600 lb. marlin the first day out and they reluctantly released it because the fish hatch would hold no more and they would have to turn back . . . Roy later got a 200 lb. ahi, a 50 lb. ulua and a 40 lb. mahimahi . . . Ted caught a 50 lb. ahi, and a large ulua on a spin tackle among others . . . Tom landed a 200 lb. marlin and lost an even larger one. The sunburned unshaven trio returned with mempachi, aku etc. etc. brimming the hatch . . .

Another fisherman extraordinare is **Kaoru Sasaki** who in July got a 675 marlin on a 80 lb. test line which he pulled in hand over hand in 45 minutes because the tackle would be too slow . . . since his misadventure several years ago when he was swamped all alone in the briny deep . . . Kaoru now goes out with a fishing companion . . .

Of Golfers: Our favorite touring pro, **Dick Ho** played in the Kaiser International Open held on Sept. 21 at Napa, California. Dick shot a gross 75 to win both low gross and low net in the Amateur Division in a field of 200. He settled for low gross and a TV set . . .

Of Paddlers: Kailua internist **Dale Adams** formerly bicycled 60 to 80 miles daily to and from his Waikiki home to his Kailua office . . . Then during a State Championship Race in June last year, a four bike pile-up broke a few ribs, fractured his clavicle and caused pulmonary embolism to boot . . . So Dale switched peddles for paddles . . . He moved to Kailua and started paddling a surfboard for rehabilitation . . . Then he purchased a one man 17 foot kayak . . . Dale would paddle to work, paddle to Bellows Air Base and back during noon and then paddle home at night. Even this routine became tame . . . He decided to paddle the treacherous 35 mile Molokai Channel . . . Which he did on Sept. 12 . . . What next?

Charley Cachero's Repertoire

Heard during the recent Path Associate's Kuilima Golf Tournament banquet)

"We thank **Paul Tamura** and the Path Associates for this evening . . . Karen (Paul's secretary and tournament coordinator) had asked me to tell a few jokes, but I had not expected such an audience" (Charley looked askance at the youngsters in the audience for he felt somewhat stifled) But he proceeded bravely . . .

"I'm going to tell a golf story first . . . A young handsome golfer playing alone was about to tee off the first hole. An attractive young lady golfer asked if she could join him . . . After 9 holes, they were all even. He was impressed . . . 'Say Mary, what's your handicap?' 'Well, Bob, mine is 14.' 'Tell you what . . . Mine is 10 so I'll give you 2 strokes on the next 9 and we'll play for drinks . . .' She agreed . . . As they ap-

HIGUCHI INSURANCE AGENCY, INC.

(808) 531-7091

HONOLULU COUNTY MEDICAL SOCIETY'S
INSURANCE PROGRAM ADMINISTRATOR

TERM LIFE INSURANCE
DISABILITY INCOME INSURANCE
MAJOR HOSPITAL INSURANCE
DEFENDANTS REIMBURSEMENT INSURANCE

proached the 18th green, they were all even and both lay 2 on the green . . . As Bob lined up his 30 foot putt, he said, 'If I sink this putt, I'll treat you to dinner and dancing.' Kerplunk! His putt went in . . . Mary with a 25 footer promised, 'If I sink mine, after your dinner and dancing, I'll invite you to my apartment for coffee, drinks and loving . . .' Before she could putt, Bob picked up her ball and declared, 'This is a gimmee!' "

"One evening, the father was watching his favorite TV program when his 5 year old daughter asked endearingly, 'Daddy . . . Will you whisper in my ear like you do mom?' So the father obligingly leaned over and whispered, 'I love you Honey . . .' The daughter whispered back, 'Not tonight Darling . . . I have a headache . . .'"

"The 6th grade class was getting restless so Miss Jones, the teacher decided to liven up her class . . . 'Class, I want each of you to go up to the board and write an interesting sentence.' So each student went up and wrote a sentence . . . ie, all except Johnny who simply drew 2 dots . . . Miss Jones asked, 'Johnny, that's not a sentence.' Johnny explained, 'Teach . . . Remember you taught us that a dot is a period . . . Well, dad and mom were quite upset last night when my sister missed two periods . . .'"

"The other week with Hurricane Karen closing in on the islands, I was at St. Francis Surgery where I heard this joke . . . 'What did Hurricane Karen say to the coconut trees?' 'Better hold onto your nuts . . . This is no ordinary blow job.' "

"In anatomy class, the instructor asked a student nurse . . . 'What part of the body expands 10 times its normal size?' The student blushed and stammered, 'I'd rather not answer that.' The instructor admonished, 'Young lady! You haven't studied your lesson . . . Moreover you may be in for a big disappointment . . . The answer is the pupil of the eye.' "

6th Annual Kuakini Hospital Golf Tournament

(Held May 28 at Mid Pac)

Forty aspiring golfers playing on a beautiful Friday afternoon competed in 2 men aggregates, individual jackpots, and for low net and low gross prizes . . . The overall individual jackpot winners were **Garth Morimoto** and **Ed Izawa.** The first 9 winners were: **Tom Fujiwara** tied for 1st place, **Ike Nadamoto, Dick Omura** and **Don Maruyama** tied for 4th. The 2nd 9 winners were: **Frank Fukunaga** tied for first, **Al Parez** in 3rd, **Herb Takaki** in 4th and **Clarence Sakai** in 5th place . . .

Tied for 1st place net were **Al Paraz, Francis Fukunaga** and hospital VP **Ron Oka** with 66's . . . Five tied for 2nd place at net 69: **Dick Omura, Ike Nadamoto, Tom Fujiwara, Eugene Matsuyama** and **Herman Mercado.** In 3rd place was **Ed Izawa** all alone with net 70. 4th place had five net 71's: **Paul Sunahara, Mike Okihiro, T. Yamashita, Don Maruyama,** and **Herb Takaki. Hideo Oshiro** with net 72 was alone in 5th place. Net 74's were **T. Kawasugi** and **Art Salcedo.** Net 75's were **Masa Koike, Tad Iwanuma,** and **Glenn Kokame.**

Miscellany

It seems that three surgeons at St. Francis Hospital were comparing notes . . . One surgeon said the Japanese were the easiest to operate on since all their parts were transistorized . . . The second surgeon insisted that the Hawaiians were the simplest since they had no moving parts . . . But the 3rd surgeon disagreed: "The Portugnese are the easiest since they have only two moving parts (pointing to his mouth and to his anus) which are interchangeable . . ." **Editor's note:** *Those who feel that ethnic jokes are racist do not really understand Hawaii . . . No one here believes there is any truth to the ethnic characteristics depicted. Some of our best friends are Portuguese, Hawaiians, or Filipinos and they tell us the best ethnic jokes . . . The expression "Lucky you live Hawaii" says it all.*

"Our Angels"

	Page
Aina Haina Professional Building	339
American Security Bank	326
Beltone Electronics Corporation	331
Century Pacific, Inc. *Jockey Club*	327
Herbert K. Horita Realty, Inc. Waialae Iki IV	345
Higuchi Insurance Agency	348
Hilo Care Center	346
Eli Lilly and Company	332
Pharmaceutical Manufacturers Association	352, 353
PVO International, Inc. *Saffola*	354
Roche Laboratories *Dalmane*	350, 351
Valium	324, 325
Roerig *Marax*	328, 329, 330
Williams Mortuary	349

WILLIAMS MORTUARY

"CHAPEL OF THE CHIMES"

1076 S. Beretania St., Phone 537-2587 **Ample Parking Adjoining Mortuary**

OVER A CENTURY OF SERVICE

"Service measured not by gold but by the Golden Rule"

MEMBER

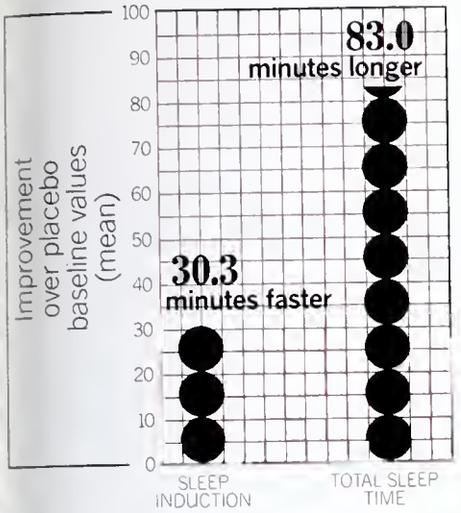
National Selected Morticians, National Funeral Directors Association, Order of the Golden Rule, Hawaii Funeral Directors Association

The ultimate objective test: sleep laboratory proof of effectiveness . . . now in geriatric insomnia patients

Six female insomniacs, ranging in age from 67 to 82 years, received Dalmane (flurazepam HCl) for seven consecutive nights in the sleep research laboratory.[1] Improvement over pre-treatment baseline levels was significant for sleep induction and sleep maintenance ($p < .05$). And the greater the sleep problem in these patients, the better the effect with Dalmane (significant correlation at $p < .01$ level).



Elderly insomniacs fell asleep faster, slept longer[1]



Results expand and confirm objective proof of efficacy in younger adults with insomnia

The effectiveness of Dalmane (flurazepam HCl) was demonstrated in earlier studies of 32 younger adults with trouble falling asleep, staying asleep or sleeping long enough.[2] On average, in these studies, Dalmane induced sleep within 17 minutes and provided 7 to 8 hours of sleep, at the same time reducing number of nighttime awakenings.

Relative safety, even in patients on warfarin

Morning "hang-over" has been relatively infrequent with Dalmane. And no unacceptable fluctuation in prothrombin time has been reported in warfarin patients on Dalmane.[2,3] The usual adult dosage is 30 mg *h.s.*; in elderly and debilitated patients, limit initial dosage to 15 mg to help preclude oversedation, dizziness or ataxia.

Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

REFERENCES:

1. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
2. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
3. Robinson DS, Amidon EL: Interaction of benzodiazepines with warfarin in man, in *The Benzodiazepines*, edited by Garattini S, Mussini E, Randall LO. New York, Raven Press, 1973, p. 641

New evidence proves insomnia relief in elderly patients

Dalmane®
(flurazepam HCl) Ⓒ IV

One 15-mg capsule *h.s.*—initial dosage for elderly or debilitated patients.
One 30-mg capsule *h.s.*—usual adult dosage (15 mg may suffice in some patients).

For all common types of insomnia

ROCHE

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110


RECENT CHANGES
federal register
Providing Drug Information to Physicians
Informational Bulletin # 433-76
National Health Insurance
special report
Malpractice insurance:
drug Bulletin
Health care doesn't need more red tape
Drug firms challenge 'MAC' rules
Drug Substitution
The Common Denominator of Health Progress
RESEARCH
Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.

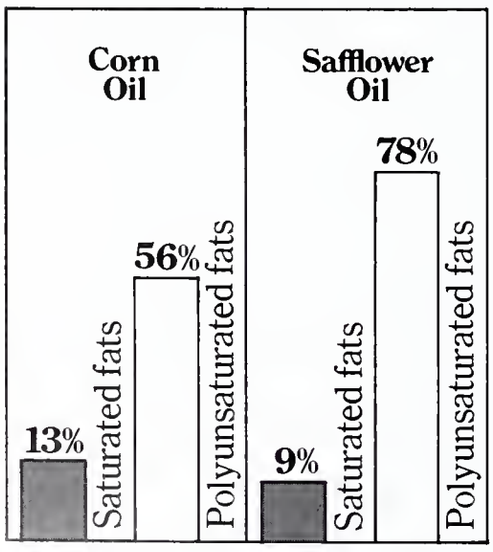


Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

The margarine highest in polyunsaturates doesn't contain a drop of corn oil.

Shouldn't you spread that around?

Saturated fats and polyunsaturated fats in Corn and Safflower Oils



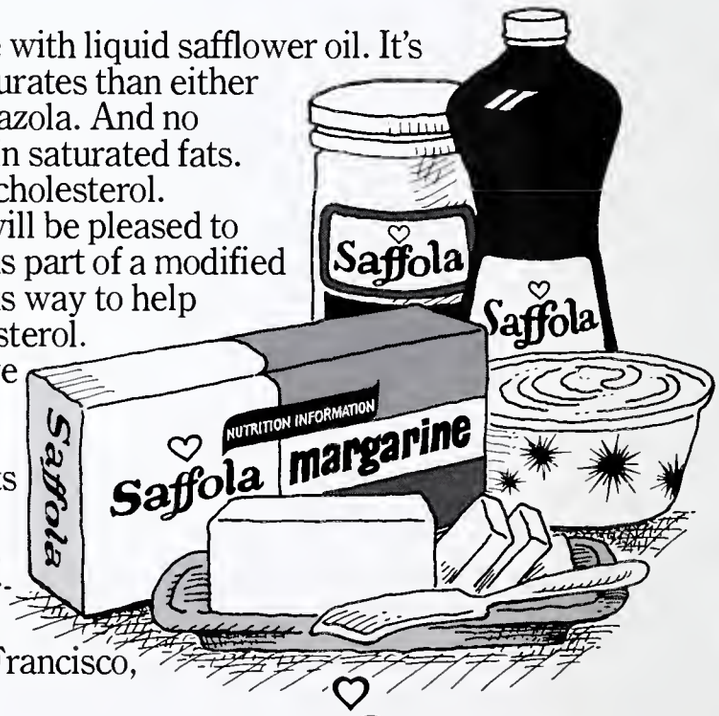
LIMITED WARRANTY TO CONSUMERS
Good Housekeeping PROMISES
REPLACEMENT OR REFUND IF DEFECTIVE

All Saffola products have earned the Good Housekeeping Seal.

Saffola is made with liquid safflower oil. It's higher in polyunsaturates than either Fleischmann's or Mazola. And no margarine is lower in saturated fats. Saffola contains no cholesterol.

Your patients will be pleased to know that Saffola, as part of a modified fat diet, is a delicious way to help reduce serum cholesterol.

For comparative nutritional information on all of our safflower oil products write: Consumer Products Division, PVO International Inc., World Trade Center, San Francisco, California 94111.



Saffola®

Enjoy it to your heart's content.

DECEMBER, 1976
VOL. 35, NO. 12

Hawaii Medical Journal

CONTENTS

Clinical Pharmacology: Hard Sell or Soft? 363
Louis Lasagna, M.D.

Prevalence of Rodent Endemic Typhus on the Island of Maui 366
Harry H. Higa, Ph.D., Alice M. Broadhurst, M.D.

Continuing Medical Education 411

Editorials 374

Hawaii Academy of Family Physicians' Newsletter 413

HMA Newsletter 372

Letters to the Editor 359

New Members 413

News & Notes 414

President's Message 372

Proceedings of the House of Delegates 375

The Library
Acquisitions Division SP
University of California, San
Francisco
San Francisco California 94143

LIBRARY
U.C. SAN FRANCISCO
FEB 1 1977

Both often



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium®
(diazepam) Ⓘⓥ

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

We're the only lab in the islands affiliated with Bio-Science.

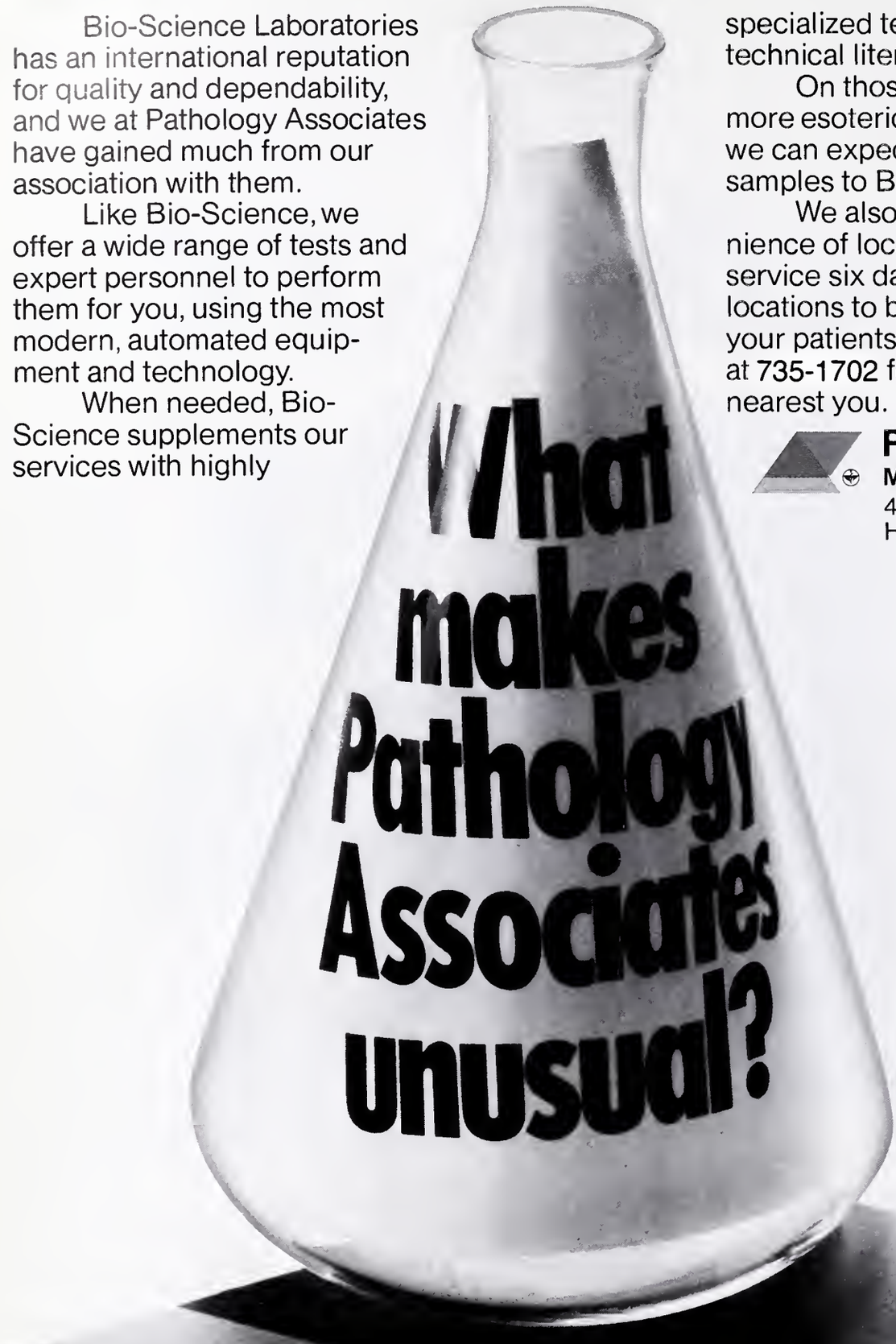
Bio-Science Laboratories has an international reputation for quality and dependability, and we at Pathology Associates have gained much from our association with them.

Like Bio-Science, we offer a wide range of tests and expert personnel to perform them for you, using the most modern, automated equipment and technology.

When needed, Bio-Science supplements our services with highly specialized test procedures and technical literature.

On those occasions when more esoteric assays are required, we can expedite sending your samples to Bio-Science for you.

We also offer you the convenience of local pick-up and stat service six days a week with eight locations to better serve you and your patients. Call our main office at 735-1702 for the branch nearest you.



Pathology Associates
Medical Laboratories
4400 Kalanianaole Hwy.
Honolulu, HI 96821

An Affiliate of
Bio-Science Laboratories

HAWAII MEDICAL JOURNAL

Published Monthly by the
HAWAII MEDICAL ASSOCIATION
(Incorporated in 1856 under the Monarchy)
320 Ward Avenue, Honolulu, Hawaii 96814

EDITORS

Editor, HARRY L. ARNOLD, JR., M.D.
News Editor, HENRY N. YOKOYAMA, M.D.
Assistant Editor, DORIS R. JASINSKI, M.D., M.P.H.
Associate Editor, J.I. FREDERICK REPPUN, M.D.
Executive Editor, PAUL STEWARD

OFFICERS

President, CALVIN C.J. SIA, M.D.
President-Elect, MARION HANLON, M.D.
Past President, WILLIAM W.L. DANG, M.D.
Secretary, DOUGLAS B. BELL II, M.D.
Treasurer, GROVER H. BATTEN, M.D.

County Presidents

Hawaii, KENNETH HUGHES, M.D.
Honolulu, ANN B. CATTS, M.D.
Kauai, THATCHER MAGOUN, M.D.
Maui, CLIFFORD MORAN, M.D.
Delegates to AMA, GEORGE H. MILLS, M.D.
HERBERT Y.H. CHINN, M.D.
Alternate Delegates to AMA,
WILLIAM W.L. DANG, M.D.
WILLIAM E. IACONETTI, M.D.

Advertising Representatives
National:
HAWAII MEDICAL ASSOCIATION
320 WARD AVENUE
Honolulu, Hawaii 96814
Phone (808)536-7702
Honolulu:
LILITH JURRY, Phone 946-0053

THE JOURNAL may not be held responsible for opinions expressed in papers, discussions, communications, or advertisements. The advertising policy of the HAWAII MEDICAL JOURNAL is governed by the rules of the Council on Drugs of the American Medical Association. The right is reserved to reject material submitted for editorial or advertising columns. All material for publication must be in the hands of the editor on or before the 10th day of the month preceding publication date. Reprints of original articles will be supplied at actual cost. A reasonable number of illustrations accompanying an article will be accepted for printing. The right is reserved to ask the author to bear cost of these when it is found necessary to do so.

Copyright 1976 by the Hawaii Medical Association, Honolulu, Hawaii. 2nd class postage paid at Honolulu, Hawaii. Office of Publication: 320 Ward Avenue, Honolulu, Hawaii 96814.



To The Editor:

Health Screening for the Elderly, sponsored by Hawaii Senior Services and funded through Regional Medical Program of Hawaii, has completed 22 months of operations.

Over 2,500 persons have been screened, 1,608 having 4,001 abnormal test results. These participants were referred to their PMD for evaluation. Follow-through, to assure that participants go for physician evaluation, was completed on 87% of those referred.

Physician evaluations have been received on 44.1% of those referred. 8.7% have previously undetected health abnormalities. 9.1% were medical care "dropouts," and now are continuing treatment. A sincere mahalo to you who have taken time to fill out and return these evaluations. They help us check the accuracy of our tests, and whether participants go for a physician's evaluation.

Statistics help, but don't tell the whole story. Continuing emphasis on health education—understanding the necessity of regular medical care, and understanding personal responsibility for good health practices—will have long range results.

Future screenings will be held in Kalihi/Palama, Haleiwa, Waimanalo, Kaimuki/Palolo, Waipahu and Pawaa/Makiki. Included are registration and health history, urine test, height and weight, blood test for anemia and diabetes, blood pressure check, vision test (Snellen), tonometry check, hearing check (audiometry) and exit interview. Oral Cancer screening, and pap and breast exam are included, when scheduling permits.

For further information, contact Mrs. Reta Maag (523-1602).

RETA MAAG

continued page 422

aggravating



...allergic dermatoses

with strong emotional overlay

Atarax®

(hydroxyzine hydrochloride)

TABLETS: 10 mg, 25 mg, and 50 mg

- rapid antianxiety action
- demonstrated antihistaminic activity

Contraindications: Hypersensitivity to hydroxyzine. Hydroxyzine, when administered to the pregnant mouse, rat, and rabbit, induced fetal abnormalities in the rat at doses substantially above the human therapeutic range. Clinical data in human beings are inadequate to establish safety in early pregnancy. Until such data are available, hydroxyzine is contraindicated in early pregnancy.

Precautions: Hydroxyzine may potentiate the action of central nervous system depressants such as meperidine and barbiturates. In conjunctive use, dosage for these drugs should be reduced. Because drowsiness may occur, patients should be cautioned against driving a car or operating dangerous machinery.

Adverse Reactions: Drowsiness may occur; if so, it is usually transitory and may disappear in a few days of continued therapy or upon dosage reduction. Dryness of the mouth may occur with higher doses. Involuntary motor activity, including rare instances of tremor and convulsions, has been reported, usually with higher than recommended dosage.

Supply: Tablets, containing 10 mg, 25 mg, or 50 mg hydroxyzine hydrochloride, 100's and 500's; Tablets, containing 100 mg, 100's; Syrup, containing 10 mg per teaspoonful (5 ml) and ethyl alcohol 0.5% v/v, pint bottles.

Before prescribing or administering, see package circular.

ROERIG Pfizer

A division of Pfizer Pharmaceuticals
New York, New York 10017



The one the patient takes is never tested.

Surprising, perhaps, but it makes sense when you think about it.

Obviously, the actual dose of any prescription drug the patient takes cannot be tested because it would have to be broken down for analysis—after which it could never be used by a patient.

This means that you depend on the manufacturer for assurance that the dose the patient takes is identical to the ones which have been tested.

At each step in the manufacture of a Lilly drug, test after test confirms the ingredients, formulation, purity, and accuracy—all the critical factors that assure that every Lilly medicine is just what you ordered.

That's particularly important, as you know. The same drug made by different companies can be chemically identical yet may act differently in the human body because of the many variables in the way the drugs are manufactured.

And, of course, government standards alone do not assure the efficacy and consistency—the quality of each drug you prescribe.

As we at Eli Lilly and Company see it, the ultimate responsibility for quality is ours.

For four generations we've been making medicines as if people's lives depended on them.

600128

Lilly

ELI LILLY AND COMPANY, INDIANAPOLIS, INDIANA 46206

Windsor C. Cutting Memorial Lecture

The 1976 Windsor C. Cutting Memorial Lecture was presented at Mabel Smyth Auditorium by Dr. Louis Lasagna, Professor and Chairman of Pharmacology at the University of Rochester, School of Medicine and Dentistry. The endowed lectureship is a memorial to the late Dean of the John A. Burns School of Medicine, University of Hawaii.

Clinical Pharmacology: Hard Sell or Soft?

LOUIS LASAGNA, M.D.

Clinical pharmacology is still an infant discipline, having existed in more or less formal fashion for only two decades or so. It is, furthermore, the child of what some would consider a derivative science—pharmacology. While there are, to be sure, aspects of pharmacology that are uniquely its own, such as the dose-response relationship and pharmacokinetics, the science depends significantly on concepts and techniques that draw heavily on such sister sciences as physiology, biochemistry, and pathology.

With this background, it is perhaps not surprising that clinical pharmacology suffers from an image that is blurred and indistinct. Not only is the discipline so new that it is still being shaped, but physicians enter it with training that differs considerably from person to person, and with career interests that are highly variable. One clinical pharmacologist may be especially concerned with the methodology of controlled trials, another with the study of mechanism of action, still another with pharmacokinetics or the monitoring of drug usage or adverse reactions. The clinical pharmacologist who works for the FDA or industry has a different set of duties and responsibilities from the clinical pharmacologist who teaches. This wide variety of career possibilities is largely responsible for the attraction and excitement of the field, but it does not help clarify the role of the clinical pharmacologist.

Despite these difficulties—or perhaps because of them—fond and perhaps extravagant hopes have been generated for what the discipline could contribute to medical science and the care of the ill. In a sense, I believe that we have oversold clinical pharmacology, promised too much too soon, and grossly oversimplified some terribly complex issues. In this lecture I shall try to illustrate these points with specific examples.

Let me begin with the issue of drug levels in biological fluids. It has been asserted by some that the ability to measure drug concentrations in blood, urine, CSF, etc. would revolutionize medical practice. There are good reasons why the actual accomplishments have been much more modest.

To begin with, the hope that relatively narrow ranges could be characterized as "therapeutic" and that values below or above such ranges would be clearly sub-therapeutic or toxic has proved illusory, as one might have predicted. People not only differ considerably in their response to a given dose of a drug (because of differing elimination rates, e.g.) but may differ significantly in their response to a given blood level of drug. Consider, for example, the patient with a fresh cardiac infarct as opposed to one with long-standing and diffuse cardiac damage, or contrast a given patient with an adequate body burden of potassium with the same patient when his body is potassium-depleted. One can easily visualize the response to a given level of digoxin being quite different in these various situations.

In addition, it is clear that we are often forced to measure drug levels in biological fluids that are convenient and available rather than the site of action and interest. To the extent that our sample of the biophase is representative, this strategy will work; to the extent that it is not, we will be misled.

Furthermore, we may be ignorant of what it is we should be measuring. Is "total" drug level proper, or should we measure "free" drug? Is

Department of Pharmacology and Toxicology, University of Rochester, School of Medicine and Dentistry, Rochester, New York.

Accepted for publication August, 1976.

parent compound enough, or must we also (or instead) pay attention to active (or toxic) metabolites? For a long time it was apparent that blood levels of glutethamide often failed to predict clinical state or course in the poisoned patient. With the advent of knowledge about an active hydroxylated metabolite of glutethamide, it became possible to obtain better correlations between lab results and the level of consciousness or respiration. A similar situation obtained with regard to procainamide, whose short half-life convinced some that the drug needed to be given more often than past empiric clinical experience suggested was necessary. Now that we know that the metabolite, N-acetylprocainamide, is not only active but has a longer half-life than the parent compound, our approach to the measurement and interpretation of procainamide levels has required modification.

In the study of toxicity, drug measurements are also of limited value when the damage is caused by highly reactive metabolites that bind tightly to tissues almost as soon as they are formed. Such mischievous by-products foil the chemist by their ability to "hide" from his eye and his lab instruments. This phenomenon has been postulated for the hepatotoxicity seen with acetaminophen and isoniazid, as well as other drugs.

This is not to say that plasma drug levels are useless, but rather that they cannot answer all of our therapeutic questions. Nothing can substitute for sound clinical judgement and a weighing of all the data—if a lab result contradicts competent clinical observation, it is usually foolish to disregard the clinical findings. Measuring blood levels of drugs, on the other hand, is an extremely useful aid in the identification of both poor bioavailability and non-compliance, and can help nail down the diagnosis of drug toxicity when the values are in a grossly high range.

Another area where oversimplification has gotten us into trouble is the field of controlled clinical trials. In our zeal for randomization, we have ignored the troubles generated by failing to stratify patients on the basis of criteria likely to be relevant to outcome. Both Feinstein and Taves have pointed out the hazards of this approach, which can be expected to produce serious imbalance in important baseline variables with some frequency in trials where the sample size is modest.

A few years ago, for example, a trial attempting to assess the utility of fluoride in the management of multiple myeloma came to grief because the treated group was heavily weighted with patients suffering from serious anemia and renal insufficiency. The results suggested that the treatment was actually deleterious, but the baseline differences between experimental and control groups made it impossible to tell whether fluoride was harmful or not, or whether it might indeed be beneficial, as was originally hoped.

The field of contraception provides several examples of the limitations of the controlled trial. Much as one would like to do a truly randomized double blind trial comparing the merits and hazards of abstinence, the IUD, the vaginal diaphragm, "the pill," etc., such trials are simply not feasible with most populations. As a result we are forced to rely on such non-random studies as the one by the Royal College of General Practitioners, where careful prospective observations were made on women using either oral contraceptives or other contraceptive techniques, but where one is hampered in interpreting the data by obvious baseline differences in certain characteristics among the women who self-selected themselves into one or another group.

The Pill also illustrates the deficiencies of anything but the hugest controlled trials in assessing the capability of medicaments to produce very rare side effects. It is only by such admittedly imperfect techniques as retrospective case control studies that one can even begin to try to pin down a cause-and-effect relationship between oral contraceptives and rare thromboembolic phenomena.

At the regulatory level, we have allowed an obsession with controlled trials to obscure the fact that there are many ways to obtain knowledge about drugs. For many years we have relied on animal data and "anecdotal" case reports to give us leads as to potential or actual drug toxicity, but a double standard tends to ignore completely careful observations about therapeutic benefit made in the content of medical practice. Such a policy, coupled with a chauvinistic demand that controlled trials be repeated in the United States even when excellent foreign trials are already available, has resulted in unconscionable delays in the official approval of new drugs or the official acknowledgement of new indications for old drugs.

The emphasis on controlled trials is beset with still other problems. In the interest of homogeneous and clearly defined experimental populations, many patients are excluded from clinical trials. An additional reason for exclusion is the refusal of some patients to volunteer when informed consent is solicited, as it almost invariably is at present. Several years ago a trial of antidepressant therapy ended up with 90 subjects out of a total of 518 originally screened. One wonders whether such subjects are "typical" of the population to which one would like to generalize the conclusions of the study.

The controlled trial—like all true experimentation—is of necessity artificial, in the sense that the experimenter imposes on the subjects constraints that will allow the manipulation of one or more variables while holding others constant. Consider how different a double blind randomized trial is from ordinary clinical prac-

tice. The trial is generally performed by experts on homogeneous populations, often hospitalized, with other medications excluded insofar as possible, and excellent opportunity for insuring compliance and for monitoring both efficacy and safety. Clinical practice, on the other hand, involves physicians of varying expertise studying heterogeneous populations that are often taking other drugs simultaneously, often out of hospital and hence less able to be monitored for compliance as well as for drug effects. There are thus good reasons why the results achieved with a drug after its marketing may differ from those observed prior to the drug's release. Only by a "naturalistic" study of drugs in the real life situation can we assess the true performance of a drug, including whether doctors are using it properly or not.

In our experience with such "naturalistic" studies, we have obtained useful data that would not otherwise have been available. At our major teaching hospital, for example, we found that allopurinol was widely used for indications that are not approved and of dubious merit, such as the treatment of asymptomatic hyperuricemia secondary to thiazide diuretics or to renal insufficiency. On the other hand, we found that propranolol was being used wisely in the management of angina pectoris and hypertension despite the lag of the FDA in officially approving these indications. In evaluating drugs, whether it be for approval or removal from the market, or simply for making decisions about ordinary medical practice, our approach should involve a careful evaluation of all the evidence bearing on the performance of the drug, and not focus simply on the controlled clinical trial.

Another area which has caused trouble has been the field of bioavailability. For many years I assumed, along with many others, that USP standards were adequate, providing that drugs met them. I now realize that such a naive assumption was incorrect. Old USP standards, and even those in existence today, do not necessarily predict how a drug will perform in human beings. A tablet dissolution rate study in a beaker, even when the solution mimics the acidity of gastric or intestinal juice, is a far cry from the dissolution of a tablet and the subsequent absorption of its contents in the gastrointestinal tract. The gut is not a beaker.

My own conversion on this point was the result of seeing the data from two separate studies on the bioavailability of various versions of chloramphenicol. Here was a shocker, indeed —products approved by the FDA's own laboratories varied tremendously with some products yielding very low blood levels in volunteers. More recently, investigators in various parts of the world have reported significant variations in the bioavailability of other drugs, including digoxin and phenytoin. The troubles that we are aware of thus far almost certainly constitute only the top of the iceberg.

A variant of this theme is the ability of different salts or esters of a chemical to perform differently in animals or man. It has been known for some time, for instance, that the sodium salts of barbituates are more readily absorbed than are the acids, with demonstrable biologic implications. Some years ago the commerical availability of two closely related antibiotics, polymyxin B and colistin (which is polymyxin E), led to a great deal of disagreement about the relative efficacy and safety of the two preparations. Finally, as a result of some thoughtful laboratory work, it became clear that the major difference between these two preparations lay in the salts being used. If one used the sulfate salts of these two antibiotic bases, there was both more bacteriocidal activity and more toxicity than if one used the methane sulfonate salts, but the true polymyxins were indistinguishable. The trouble was that one antibiotic was marketed as the sulfate salt, and the other as a methane sulfonate. Another example of this phenomenon is the hepatotoxicity of erythromycin estolate. It seems clear on the basis of both clinical experience and laboratory investigation that erythromycin estolate is uniquely hepatotoxic, whereas erythromycin base and other erythromycin salts are relatively benign.

One problem that is typical of all scientific areas, but which also helps to complicate matters in regard to clinical pharmacology, is the changing status of our knowledge about drugs. Hardly a month goes by without some new effect being reported for drugs that have been with us for a long time. Thus in recent years we have learned that aspirin can cause hepatotoxicity or even pulmonary edema, and that heroin can produce a host of toxic effects which are mysterious and perplexing. The result is a constant need for updating our thinking about drugs, both old and new.

Our detailed knowledge of the metabolism of L-dopa shows how one must adapt one's approaches in the face of new knowledge. L-dopa, as ordinarily given, is an extremely inefficient drug. Grams have to be given to achieve the work of milligrams actually required in the basal ganglia. This is because much of the drug undergoes peripheral metabolism, being converted into metbolites that cannot penetrate the blood-brain barrier and produce the effects desired, namely a raising of dopamine levels in the critical diseased areas of the brain. As a result, one must consider, in some subjects the the possibility of modifying absorption by hastening gastric emptying (as with antacids), or of inhibiting peripheral metabolism of the compound by the use of dopa-decarboxylase inhibitors. Both approaches have shown themselves capable of improving performance in otherwise poorly responding patients.

The lessons from the above seem obvious (at least to me). Clinical pharmacology is an extremely important and challenging field. It has much to offer in regard to research, medical education and the delivery of health services. It is extremely important, however, that we not crystallize the discipline prematurely, that we avoid temptations to dogmatize, and that we appreciate the need continuously to revise our thinking as new information comes in. Finally, it is important that we have enough workers in the field of clinical pharmacology to tackle the various tasks that need doing.

The supply of clinical pharmacologists is inadequate to society's needs. We need to recruit more bright young physicians and to support both their training and their future careers. With more practitioners of this art will come not only more hands to do the work, but heterogeneity of opinion, more critique, and less likelihood of falling into such traps as ex cathedra assertions unsupported by evidence, the hardest sell of all.

A potential public health hazard . . .

Prevalence of Rodent Endemic Typhus on the Island of Maui

HARRY H. HIGA, PH.D.,* *and* ALICE M. BROADHURST, M.D.**, *Wailuku, Maui*

● *Serological surveillance of endemic (murine) typhus in the rats on Maui Island was performed by the use of the complement-fixation test. The Puunene location had the highest prevalence value of 54.46%. The overall prevalence value of the areas tested on Maui was 39.06%. With respect to complement fixation titers obtained, the greater occurrence of positives was at 1:128. Ninety-eight (98) of the total 348 positives (28.16%) were at this titer. The two rat species,* Rattus rattus *(roof rat) and* Rattus exulans *(Hawaiian rat), do not show definite indication as to host preeminence for this disease. The high prevalence of endemic typhus in the various areas of Maui presents a potential human health hazard.*

Endemic or murine typhus has a worldwide distribution with common occurrence in Western Europe, Central Africa, Asia, southern United States, and along the western coast of South America.[1] The first human case in Hawaii was reported in 1934.[2] Endemic typhus caused by the organism, *Rickettsia typhi*, is in general a much milder disease than epidemic or louse-borne typhus, giving an average mortality of 3.5 percent.[3] In the State of Hawaii, within the five-year period, 1970-1974, there have been 10 cases of clinical typhus.[4] (Through the Epidemiology Branch, State of Hawaii, Department of Health, it was learned that 3 of these cases occurred in 1974 so are not listed in the Statistical Report, 1973.)

Dyer et al[5] showed in 1931 that the oriental rat flea, *Xenopsylla cheopis*, was the vector of murine typhus. In the same year, Mooser et al[6] established that the domestic rat was the reservoir of this disease. Currently, it is known that the disease can also be transmitted from rat to rat and from rat to man by the rat louse, *Polyplax spinulosa*.[7] *Ctenocephalides felis*, the cat flea, has been shown to harbor *R. typhi* and has been implicated in its transmission to humans.[8]

*Vector Control Branch, State of Hawaii, Department of Health.

**Former District Health Officer, Maui State Department of Health; present address: P.O. Box 459, Wailuku, Maui 96793.

Accepted for publication May, 1976.

In 1942, Alicata and Breaks[9] reported a study of the prevalence of typhus infection in rats in various locations of Honolulu on the island of Oahu during the period, 1937-1941. They found that 73 out of 249 guinea pigs inoculated with brain emulsion of 600 rats trapped at seven locations developed typhus infections. The highest prevalences of rodent typhus were found in the Kaimuki, downtown (delineated by Ward Avenue, Iolani Avenue, and River Street), and Kalihi areas with respective prevalences of 14.0%, 21.0%, and 19.0%. One hundred rats were examined from each of these locations.

Epidemiological data from the Territorial Board of Health,[9] showed that during this period (1937-1941), there were 202 human cases throughout Honolulu. Of these occurrences, 54 (26.73%) were in Kaimuki, 26 (12.87%) in downtown, and 34 (16.83%) in Kalihi. These areas had the three highest incidences out of the total number of cases reported from 15 locations. Since the high human occurrences were in the same localities in which typhus infection in rats were found to be high, it was evident that rats play an important part in the dissemination of typhus infection to man.

During the period 1941-1944, the majority of clinical cases on the continental U.S.A., which number 16,247, were reported from the southeastern United States.[10] Subsequent to this period, there was a constant decline up to 1956. The downward trend continued with only 52 cases reported in 1967.[11]

In 1969, Older[12] conducted epidemiological studies of 12 human cases in Texas. Ten of these cases implicated fleas, *Ctenocephalides felis*, the cat flea, as vectors in the transmission of this disease to patients. In Orange County, Southern California,[13] seropositive opposums have been associated with human cases. The heavy infestation of these animals with *Ctenocephalides felis*, which readily bites man, suggested that opposums and their ectoparasites are responsible for some of the sporadic cases of typhus in man. During the studies at Orange County, there was a conspicuous absence of the classic flea vector *X. cheopis* and of seropositive rats, thereby indicating other transmission cycles.

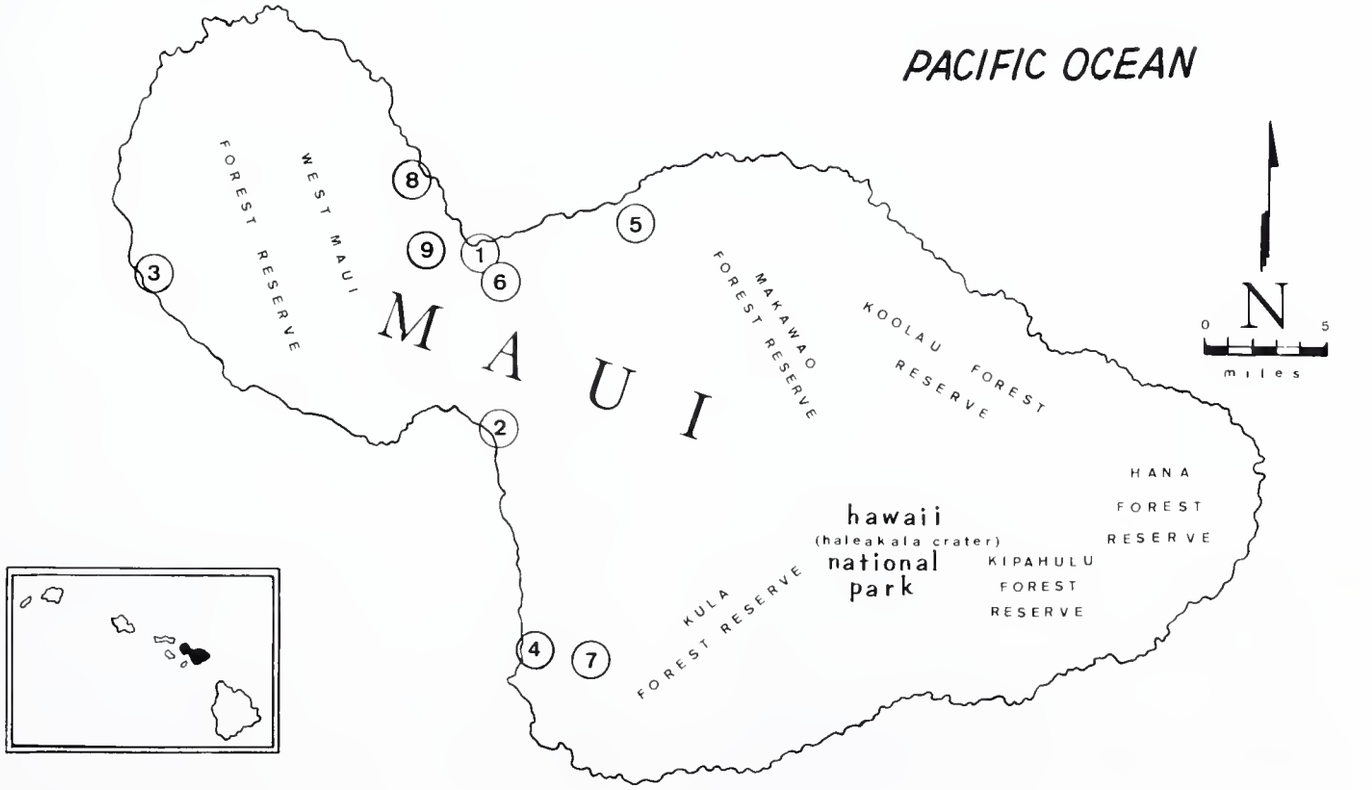
The disease in man is manifested by fever usually above 102°F, chills, headache, myalgia, weakness, fatique, anorexia, and sometimes vomiting.[14] Rashes occur in about one fourth of the cases and are often mild and localized to the trunk. Influenza has often been a common initial diagnosis.

The current study involves the prevalences of endemic typhus among rodents in the various locations of Maui. Since 1972, because of the sporadic occurrences of human endemic typhus cases, the State Health Department in Maui has carried on concentrated efforts to delineate foci of typhus infections in rats as well as to employ flea and rodent eradication measures. The data reported herein cover the period May 1972 - October 1975.

Study Area

Maui is the second largest island of the Hawaiian chain, and has an area of 728 square miles, measuring 25 miles from north to south and 38.4

FIGURE 1.—*Map of Maui showing rodent trapping areas. See Table 1 or 2 for locations corresponding to numbers on map.*



miles from east to west.[15,16] The highest point on the island, 10,013 feet, is at Haleakala Crater, a dormant volcano. Between Haleakala Crater and the West Maui mountains, lies a wide valley. The 1974 census showed the population of Maui to be 44,486. The mean monthly temperature at the Kahului Airport for the warmest (August) and coldest (January-February) months were 79.0°F and 71.7°F respectively. The average annual precipitation at the Kahului Airport, based on data as of 1973, is 16.33 inches.

The northeasterly tradewinds keep temperatures fairly cool, and because of these winds the island is designated into the windward (north) and leeward (south) sides. The maximum rainfall occurs at approximately 3,000 feet on the windward side of the highest mountains on Maui. The lowlands on the windward side receive moderate and at some places heavy rainfall. The lower leeward slopes and plains are usually arid or semi-arid.

Figure 1 shows the map of Maui with the numbers indicating the rodent trapping locations. The total number of live rats cage-trapped in the various locations is shown in Table 1. Trapping areas are located on the windward as well as the leeward sides of the island. In Table 2, the rats are categorized according to species with respect to the various locations.

Trapping in urban locations was conducted in brush close to junk yards, warehouses, libraries, schools, churches, cemeteries, and catering enterprises. In rural areas, the trapping sites were near pig, chicken, and goat pens, garages, gar-

TABLE 1.—*Prevalence of Rodent Typhus in Various Locations of Maui, Hawaii*

TRAPPING* LOCATION	RODENT			CF TITER					
	NO. EXAM.	NO. POS.	% POS.	8	16	32	64	128	256
Kahului (1)	129	35	27.13	1	3	6	9	10	6
Kihei (2)	201	82	40.80	3	6	14	22	15	22
Lahaina (3)	112	45	40.18		2	9	10	17	7
Makena (4)	22	4	18.18	1		1	1	1	
Paia (5)	232	104	44.83	3	1	12	23	33	32
Puunene (6)	112	61	54.46		4	10	14	16	17
Ulupalakua (7)	18	0							
Waihee (8)	48	13	27.08		4	1	3	5	
Wailuku (9)	17	4	23.53	1	1			1	1
Total	891	348	39.06	9	21	53	82	98	85

*Numbers in parentheses refer to trapping areas shown in Figure 1.

TABLE 2.—*Prevalence of Rodent Typhus Among Two Rodent Species According to Locations on Maui, Hawaii*

TRAPPING* LOCATION	TOTAL NO EXAMINATIONS	RATTUS RATTUS			RATTUS EXULANS		
		NO. EXAM	NO. POS	% POS	NO. EXAM.	NO. POS.	% POS.
Kahului (1)	129	105	31	29.52	24	4	16.67
Kihei (2)	201	189	74	39.15	12	8	66.67
Lahaina (3)	112	93	37	39.78	19	8	42.11
Makena (4)	22	17	3	17.65	5	1	20.00
Paia (5)	232	194	86	44.33	38	18	47.37
Puunene (6)	112	110	59	53.64	2	2	100.00
Ulupalakua (7)	18	18	0				
Waihee (8)	48	32	2	6.25	16	11	68.75
Wailuku (9)	17	16	3	18.75	1	1	100.00
Total	891	774	295	38.11	117	53	45.30

*Numbers in parentheses refer to trapping areas shown in Figure 1.

dens, and in gulches. In both sub-urban and rural areas, trapping was also conducted alongside streams and residential lots.

Materials and Methods

Serology

Sera. Serum samples were obtained from rats caught in small animal turtle-back cage traps. Adult-sized animals were anesthetized and bled from the heart.

Complement-fixation test. Sera obtained were subjected to the complement-fixation (CF) test.[17] This test has been a valuable aid in the diagnoses of rickettsial diseases in humans and also of endemic typhus in wild rats, and thus is of assistance in epidemiological or control studies.[18] This test has been employed in the serological surveillance of humans in Texas[12] and of humans and animals in Southern California.[13]

The test was conducted in the following manner: The serum samples were diluted 1:8 with water and treated with CO_2 gas to remove nonspecific and anti-complementary effects of rodent sera.[19] (CO_2 ice may also be used.) Precipitants formed in the serum samples were sedimented, and the supernatants, brought to isotonic concentration with sodium chloride, were inactivated at 56°C for 30 minutes. Serum dilution and antigen were used in 0.4 ml amounts. Five units of complement were used. Fixation was carried out at 4°C for 18 hours. Subsequently, sensitized cells made up of equal parts of washed sheep cell suspension (2.8%) and hemolysin diluted to contain 2 units per 0.1 ml were added, and the test was incubated at 37°C for 30 minutes. The tests were then centrifuged at 2000 RPM for 5 minutes and read.

Results

Endemic typhus prevalence studies by the complement-fixation test of rodents in the various locations are shown in Tables 1 and 2. A total of 891 tests were performed, with 348 positives, giving a prevalence value of 39.06%. Table 1 shows that Puunene, with 61 positives out of 112 rodents tested, had the highest prevalence, 54.46%. With respect to the complement-fixation titers obtained for the positive sera, the majority (76.15%) were in the range of 1:64 through 1:256. The greatest number of positive sera, 98 out of the 348 reported (28.16%), were at the 1:128 titer.

The high prevalence rural areas were Puunene, Paia, and Kihei, with respective values of 54.46%, 44.83%, and 40.80%. The urban area of Lahaina was 40.18%; however, those of Kahului and Wailuku were lower with respective values of 27.13% and 23.53%. High prevalence rural areas may be located on either the windward (Puunene, Paia) or the leeward (Kihei) sides.

Table 2 shows the number of typhus positive rodents according to the species *R. rattus* (roof rat) and *R. exulans* (Hawaiian rat). Although some differences occurred according to location, the overall typhus positivity for the two types of rats on Maui was not significant, i.e., 38.11% for *R. rattus* and 45.30% for *R. exulans*. *R. norvegicus* (Norway rat) was not included in Table 2 because data were not obtainable. Endemic typhus surveillance in cities such as Charleston, Orangeburg, and Sumter, South Carolina; Savannah, Georgia; and Birmingham, Alabama, involving 1,392 sera, were mostly from the Norway rat, and gave 651 positives (46.7%).[18]

Discussion

The use of the complement-fixation test in the serological surveillance of endemic typhus in rodents[13,18] and humans[11,12,20,21] is an established procedure. The specificity and reliability of this test to detect typhus antibodies is well accepted.[12,18,21]

During the initial stages in the formulation of this typhus surveillance program, it was felt that the Weil-Felix (WF) agglutination test, if employed, would facilitate serological testing because of its operational rapidity and simplicity, compared to the CF test. However, the Weil-Felix test was not employed because previous work of Brigham and Bengston[18] showed no definite correlation between the Weil-Felix and the complement-fixation tests. They found that in Orangeburg, South Carolina, out of 240 rat sera examined, 14 (5.8%) were positive by the Weil-Felix reaction and 53 (22.1%) were positive by the complement-fixation test. In experiments with white rats, these workers found that after inoculation of typhus organisms, the Weil-Felix titer appeared and persisted to approximately the fifteenth day but disappeared completely by the twentieth day, whereas with the complement-fixation test, very high titers were obtained and persisted throughout the duration of the 10-week period. At the end of 6 months, the complement-fixation titers showed a somewhat moderate drop in titer.

In isolation of demonstrable rickettsiae, they report that finding the organism is correlated much more often with the positive complement-fixation test than with the positive Weil-Felix test. They concluded that the complement-fixation reaction is a valuable aid when applied to rat control programs in preventing the spread of endemic typhus to humans.

Of the various locations studied, Puunene showed the highest endemic typhus prevalence (54.46%), followed by Paia (44.83%), Lahaina (40.18%), and Kihei (41.80%). Although climatic differences such as rainfall and temperature exist between the windward and leeward areas, the results in Table 1 show that these differences do not exert any significant influence on the oc-

currence of rodent typhus. Perhaps other factors pertaining to rat concentration and the environmental suitability of typhus transmission by the flea and/or other vectors (mite, louse) have appreciable effects on the occurrence of rodent typhus. Singly occurring human cases have been reported from Makena, Kahului, Kihei, and Puunene.

Table 1 also shows that most CF positive titers fall within the range of 1:64 to 1:256. Of the 348 CF positives obtained, 265 (76.15%) were in that range. The 1:128 titer had the greatest number of positives, 98 (28.16%) of the total CF positives. Since 76.15% of the rats examined indicate active typhus involvement, the remaining 23.85% could possibly represent incipient and/or convalescent cases.

Table 2 shows the percentages of typhus infestation in *R. rattus* and *R. exulans*. Among the rat population, *R. rattus* infestation was 38.11%, whereas that of *R. exulans* was 45.30%. This difference was not significant. In a 3-year survey at Brooks County, Georgia,[22] no significant difference in percent positive was obtained between *R. rattus* and *R. norvegicus*, although the majority of rats examined were *R. rattus*. The survey also showed that the prevalence of typhus antibodies was not significantly different in male and female rats. However, typhus antibodies were usually more prevalent in adult rats than in young rats.

Locations with relatively high rodent typhus infection rates such as Kihei (36.49%), Lahaina (40.18%), Paia (45.89%), and Puunene (54.46%) may be considered as high risk potential areas and may result in the spill-over of the disease into the human population without adequate control measures. The spill-over of the disease into the human population is governed by various factors such as the presence of sufficient number of vectors, the rodent population densities and their infection rates, and the probability of the human population coming in contact with the infected rodents and vectors. As a preventive measure against any spill-over into the human population, the Maui Health Department, Vector Control Branch, has been actively engaged in rodent and flea eradication procedures, insofar as staffing has permitted.

Summary

Serological results of endemic typhus surveillance of rats at various locations on Maui are reported. The serological test employed was the complement-fixation test. The Puunene location showed the highest prevalence (54.46%) of endemic typhus, followed by other relatively high prevalence areas such as Paia (44.83%), Lahaina (40.18%), and Kihei (41.80%). These areas represent both the windward and the leeward areas of Maui. Difference in climatic conditions does not appear to influence the occurrence of endemic typhus among the rat population.

There were 348 CF positives out of the total 891 sera tested. The majority of the CF positive titers (76.15%) were within the range of 1:64-1:256. Among the two species of rats (*R. rattus* and *R. exulans*) tested, the respective prevalence values were 38.24% and 45.30%. This difference was not significant.

The high endemic typhus prevalence values in the various locations of Maui indicate the need for the on-going rodent control measures to prevent the spillage of endemic typhus into the human population.

Acknowledgement

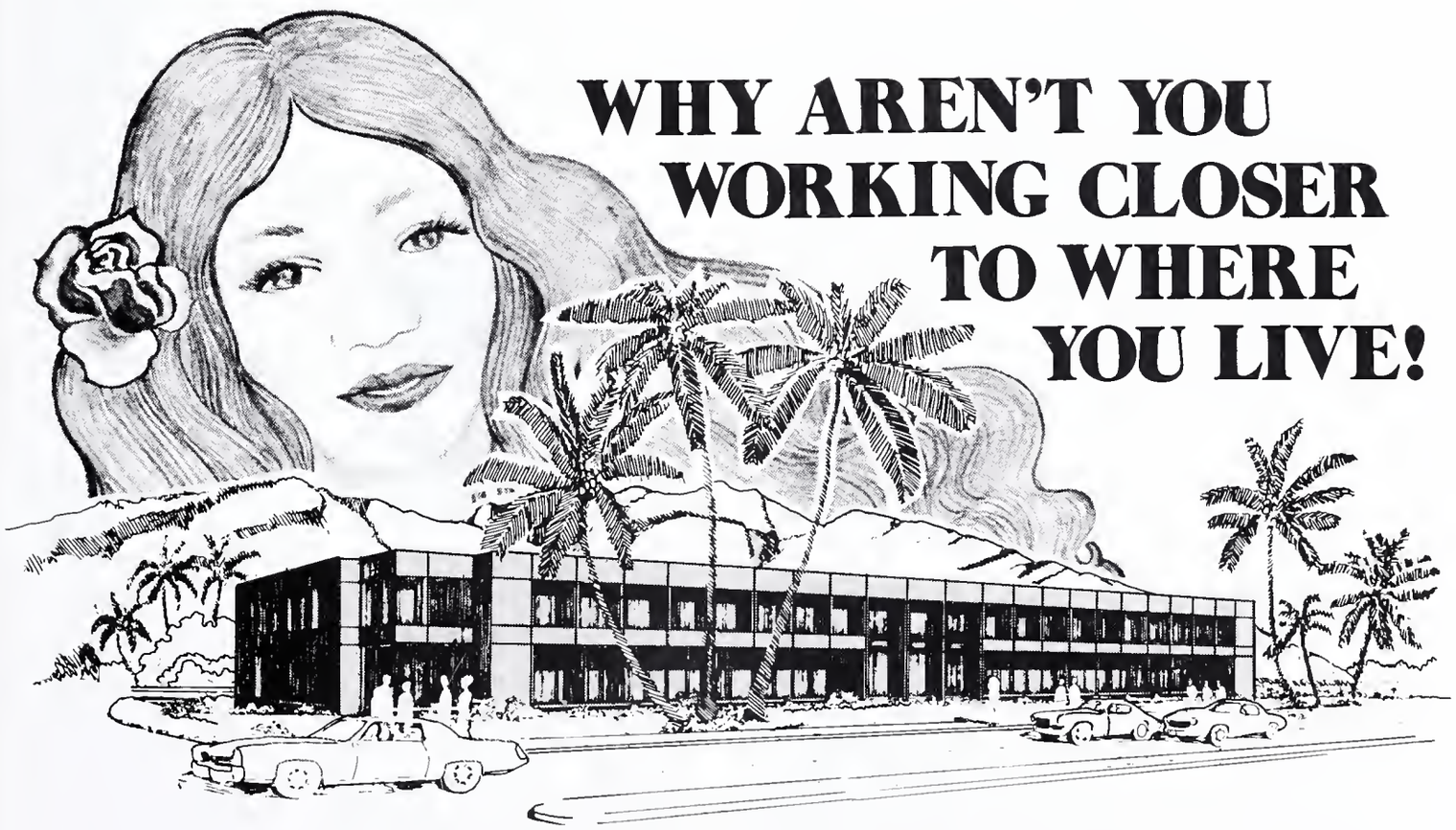
The authors wish to thank Mrs. Erika Wilson and Mrs. Arlene Kabei for technical assistance, particularly, in the performance of the complement-fixation tests. We are also indebted to Mr. Joseph Duarte, supervisor, Vector Control Branch, Maui Department of Health, for coordinating all rodent trapping and bleeding activities.

(The rickettsial antigen and control antigen, the guinea pig complement, and the hemolysin were obtained from the Beckman Instruments, Inc., 2500 Harbor Boulevard, Fullerton, California and sheep red blood cells were obtained from Bioquest, P.O. Box 175, Cockeysville, Maryland.)

REFERENCES

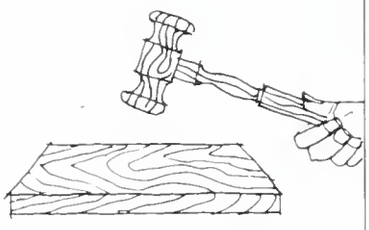
1. Love GL, Smith WW: Murine typhus investigation in southwestern Georgia. *Pub Health Rep* 75: 429-440, 1960.
2. Fennel EA: Endemic typhus fever in Honolulu. JAMA 102: 1135-1136, 1934.
3. Smith DT, Conant NF, Willet HP: *Zinser Microbiology*, Fourteenth Edition, New York: Appleton-Century-Crofts, 1968.
4. Department of Health: *Statistical Report* (Supplement), State of Hawaii, p. 54, 1973.
5. Dyer RE, Rumreich A, Badger LF: Typhus fever, a virus of the typhus type derived from fleas collected from wild rats. *Pub Health Rep* 46: 334-338, 1931.
6. Mooser H, Castaneda MR, Zinnser H: Rats as carriers of Mexican typhus fever. JAMA 97: 231-232, 1931.
7. Burrows W: *Textbook of Microbiology*, Nineteenth Edition, Philadelphia: WB Saunders Company, 1968.
8. Irons JV, Bohls SW, Thurman DC Jr, et al: Probable role of the cat flea, *Ctenocephalides felis*, in transmission of murine typhus. *Am J Trop Med and Hyg* 24: 359-362, 1944.
9. Alicata JE, Breaks V: Typhus fever in Honolulu. *Hawaii Med J* 2: 59-62, 1942.
10. Pratt HD: The changing picture of murine typhus in the United States. *Ann N York Acad Sci* 70: 516-527, 1958.
11. Mellin H, MacGibbon JB, Levitt LP, Janney JH: Murine typhus: Recent United States surveillance and report of an unusual case. *Md State Med J* 19: 56-58, 1970.
12. Older JJ: The epidemiology of murine typhus in Texas, 1969. JAMA 214: 2011-2017, 1970.
13. Adams WH, Emmons RW, Brooks JE: The changing ecology of murine (endemic) typhus in Southern California. *Am J Trop Med and Hyg* 19: 311-318, 1970.
14. Older JJ: Epidemiology of Rocky Mountain spotted fever and murine typhus. *Tex Med* 66: 42-45, 1970.
15. Phillip DF: *Diversified Agriculture of Hawaii*, Honolulu: University of Hawaii Press, 1953.
16. Davenport WW: *Fodor's Hawaii*, New York: David McKay Company Inc., 1971.
17. Casey HL: Standardized diagnostic complement-fixation method and adaptation to micro test. I. Laboratory Branch complement-fixation method by Laboratory Branch task force. II. Adaptation of LBCF method to microtechnique. Pub

Health Mongr 74: 1-34, 1965; Public Health Service Publication No. 1228, U.S. Government Printing Office, Washington, D.C.
18. Brigham GD, Bengston IA: A study of the complement-fixation and Weil-Felix reactions in wild rats as related to the isolation of the virus of endemic typhus. *Pub Health Rep* 60: 29-46, 1945.
19. Iman I, Ally L: The elimination of the anti-complementary reaction of the sera by CO_2. *J Egypt Pub Health Assn* 41: 33-36, 1966.
20. White PC Jr: A brief historical review of murine typhus in Virginia and the United States. *Virginia Medical Monthly* 97: 16-23, 1970.
21. Bengston IA, Topping NH: The specificity of the complement-fixation test in endemic typhus fever using a rickettsial antigen. *Pub Health Rep* 56: 1723-1727, 1941.
22. Morlan HB, Utterback BC, Dent JE: Domestic rats, Rat ectoparasites and typhus control. Part I. Domestic rats in relation to murine typhus control. Pub Health Mongr 5: 3-20, 1952; Public Health Service Publication No. 209, U.S. Government Printing Office, Washington, D.C.



If you live within the Kahala to Koko Head area, and are more than a little tired of the traffic, it just might be time to look into the Aina Haina Professional Building.
It really is a lovely building and of course the location alone may be the best feature to you.
Areas from 300 to 6,000 square feet are available with some very enticing leasing arrangements.
For information on how you can work closer to where you live, call:

AINA HAINA PROFESSIONAL BUILDING - 524-2023



President's Message

As we begin our new year together, I hope that this section of our Journal can help me communicate with you some of my concerns and issues as your new President of the Hawaii Medical Asociation. Our recently completed annual meeting and the House of Delegates deliberations made me reflect on the direction this Association is taking. It is a reaffirmation of the deep concern we all have for the total care of the patient and his family, a sense for his "quality of life." This quality of life in recent years has become not only the concern of medicine but also that of the social scientists, the educators, psychologists, environmentalists, and many, many others. Government with its ever increasing and expanding bureaucracy has also actively focused in this area. The flood of legislation each session locally and nationally indicates the public's concerns and attempts to control this "quality of life" that for many years was under our domain. It is because of these pressing forces that physicians must unite under organized medicine to offer leadership in this area, concentrating on medical health care, health education, and research. We must begin to act rather than react to these changing times. Our voice can be heard if it is representative of all of us but not as an individual "crying in the wilderness."

The dialogue and "cross-fires" during the Reference committee hearings of the House of Delegates meetings offered us a challenge to get together and seek out positive programs for our patients, community, state, and nation. The fervor that was asserted by many of the individuals with the various issues during the meetings should continue to be stimulated so that we, as an organization, can make our voices heard in unison. We should continue to have open dialogue on various critical issues this coming year and resolve these problems within our family early!

For the coming year, malpractice is our top priority. Two Ad Hoc Committees have been appointed and formed. One is chaired by Dr. Leonard Howard to study Act 219 with specific recommendations to amend the compulsory insurance clause for licensure, and deal with the statute of limitations and other parts of the law. The second is chaired by Dr. John Edwards and is to study the feasibility of developing a self-insurance program for the Association. Other priority items relate to the developing Cancer Center and HMA's role in it, the Emergency Medical Service program, Continuing Medical Education, Health Manpower, Health Planning Act under PL 93-641, and our new building management. I hope that you will feel free to communicate with me directly or to any member of Council during this coming year on any of your concerns or problems. This is your organization and we are here to represent you. The Committee and Council meetings are open for your attendance. Get involved with your organization and let's begin this new year with open communications!

Aloha,
CALVIN C.J. SIA, M.D.





JON WON

AMA Clinical Session, Dec. 4-8, 1976, in Philadelphia, has just ended. House of Delegates took on 174 separate pieces of business. The biggest issue was AMA position on national health insurance. It produced over 2 hours of testimony in the reference committee and just as long in the House itself. Basically, by a large majority, the AMA House adopted a position of supporting House Bill 6222 in the next session of Congress. This is the bill that the AMA has sup-

ported in the past few years. Another issue was the idea that the AMA conduct direct billings to members for its dues. Much debate created over this proposal by the Board of Trustees. The Trustees indicated that this proposal was introduced in order to inform the state and county societies about the problems that AMA has in trying to cope with some 600 different billing systems around the country and that any alternatives that would assist the AMA would be welcome. Testimony on this issue favored the idea that the AMA should be allowed to direct bill **IF** the state association approves of the AMA doing this for a particular county or state. HMA supported this position.

Particulars of all actions will be forthcoming to all physicians via the *American Medical News*. HMA ably represented at this meeting: Delegates George Mills and Herb Chinn; Alternate Delegate Will Iaconetti; HMA President-elect Marion Hanlon; Exec. Director John Won.

AMA president Richard E. Palmer, M.D., in his address to the AMA House of Delegates, noted that the AMA must, in the words of General George S. Patton, Jr., "Go Forward—always go forward." And in doing this, Dr. Palmer believes that the AMA must be a staunch adversary of what the medical profession opposes; yet, at the same time, in order to be a credible and effective adversary, the AMA must be a worthy advocate, to be positive, for negativism is usually a synonym for nowhere and for getting nowhere.

Public Law 93-641, the so-called health planning law, was the topic of a three-hour session at the AMA Clinical Session (good for three hours of AMA Category I credit). Presentations included the outlook for this law from the sides of the government, the medical profession, and the insurers. The AMA's joint suit with the State of North Carolina contesting the constitutionality of this law is being pursued vigorously, but, in the meantime, it is the law of the land, and physicians must become involved, for, if the law is upheld by the courts, the medical profession can be assured that Congress will make this law even more arbitrary and disruptive in the future. The federal government is proceeding; it has to. The medical profession must wait for the outcome of the court actions and become deeply involved in this program.

HMA President Calvin Sia, M.D., is in the process of completing his appointment of committees. Appointments are being sent to physicians that have been selected. These committees are the backbone of **YOUR** medical association. Please make every effort to attend the meetings when they are scheduled.

Continuing Education Division of the U of H wants to know if any physicians are interested in signing up for an evening course on statistics for the profession. Requests have been such that if enough interest is demonstrated, the course can be established. If you are interested, just give the HMA office a call at 536-7702.

Physician-Owned Professional Liability Companies have sprouted all across the country. Claims of success and failure are varied. The HMA has an ad hoc committee to study all various and sundry approaches and the various alternatives and consequences for Hawaii's physicians. A number of these alternatives are being pushed locally. It must be clearly understood that there is no magic solution—that one particular approach stands out so much that it is an automatic answer. This ad hoc committee will study all of the issues in as much depth as possible and, hopefully, will be able to recommend a sound, reasonable direction for the HMA.

Opportunities for Physicians seem to abound:

Hickam AFB has two vacancies: Medical Officer (Pediatrics) and Medical Officer (General Practice). For information, call HMA office or direct inquiries to Civilian Personnel Office, 15 Air Base Wing CPCC, Hickam AFB, HI 96553, tel. 449-6733.

Tripler Army Medical Center needs Medical Officer (Pediatrics), GS-602-12. Tour of duty 8 to 4:30 p.m., Mon. thru Fri., base salary $26,571 plus cost of living allowance to eligible candidates. Contact Miss Barbara Deeb or Mrs. Myrna Fong, Fort Shafter Civilian Personnel Office at 438-9227 no later Jan. 31, 1977.

Kohala Dispensary, Big Island, needs permanent physician in general practice; also needs physician for *locum tenens* during June, July, August, 1977. Salary open depending on background. Contact Dr. Michael Padwick, P.O. Box 99, Kapaau, Hawaii 96755, or call Big Island 889-6247.

Hawaii State Hospital needs Internist and Ob-Gyn as well as Psychiatrists. Internist and Ob-Gyn to conduct clinics one morning/week, time varies, pay is fee-for-service at $28.80/hour. Positions available January. Also need internist immediately on fee-for-service basis for 2 to 4 hour coverage daily in Medical-Geriatric Unit. Contact Dr. Ernest Fogelberg, Clinical Director, Hawaii State Hospital.

Cancer Center of Hawaii seeks Associate Director for Cancer Control and Education Programs. Full-time position, federal funds pending. Must have M.D. or Ph.D. Salary open depending on background. Information from HMA office, or direct inquiries to Dr. Lawrence H. Piette, Executive Director, Cancer Center of

Hawaii, 1997 East-West Road, Honolulu, HI 96822. Closing date is Dec. 31, 1976.

"Dang Plan" Reminders have been sent to all HMA members. Option selection and remittance of appropriate amount (depending on the option selected) are *due by December 31, 1976.* This plan was adopted by the 1975 House of Delegates with your association's welfare in mind. If you still have not seen your new home, please stop by—it'll be worth your time.

Medical Assistants, or the "people in the doctors' office," are a misunderstood breed of allied health professional, especially by many physicians. Regardless of educational background and/or training, the personnel in your office—in the front, or helping the back—are medical assistants. These medical assistants themselves have developed their own standards of training and standards of practice with you, the doctor, in mind. There are three certification programs for medical assistants—administrative, clinical, and pediatrics—that are available. Every physician should become knowledgeable about these allied health personnel and what they can do for the doctor, for it is the doctor that they serve.

HAMPAC and the 1976 Elections. For those physicians who think in terms of figures here is how candidates for the Hawaii House of Representatives who were supported by your Hawaii Medical Political Action Committee fared in the November general election. Of the 48 House candidates HAMPAC contributed to, HAMPAC backed 40 winners and 8 losers. This is a winning percentage of 83%. HAMPAC also backed winners in both the U.S. Senate and U.S. House of Representatives.

HAMPAC's support for these candidates will open the doors for HMA's legislative efforts during the 1977 legislative session and assist in amending the objectionable provisions of Act 219. Legislators will need our continuing support during this off-election year just as we need their continuing support to permit us to continue the practice of our profession with conscience and dignity.

All physicians and their spouses can assist in HMA's legislative effort by joining or renewing their membership in HAMPAC at the time of payment of 1977 medical society membership dues. HAMPAC dues are $20 for physician or $30 for physician and spouse. Your 1977 dues statement will include an itemization for your voluntary HAMPAC membership contribution.

1977 AMPAC/HAMPAC Seminar. AMPAC is sponsoring a half-day public affairs and political education Seminar for physicians and their spouses on Saturday afternoon and evening February 5, 1977. The Seminar will stress the active year round political participation and commitment of the medical community.

A national political figure will provide the keynote address at the closing dinner. Mark your calendar now to reserve Saturday afternoon and early evening for you and your spouse to attend. Registration details will be furnished at a later date.

Medical Assistants Workshop. The Bureau of Medical Economics of Honolulu is sponsoring a series of workshops for Medical Assistants on Wednesday March 2nd and Thursday March 3rd, 1977. The workshops are especially designed by the AMA, in cooperation with the American Association of Medical Assistants, to improve the communication skills of the medical provider's office staff and assist in expediting the collection of medical accounts. The workshops will be conducted by Karen Zupko, program director in the AMA's Department of Practice Management. A $25 enrollment fee includes course materials and lunch for both the morning session of "You, The Telephone Manager" and afternoon session "Medical Collection Manage ment". Enrollment will be limited to 50 persons for the morning communication session, and 75 persons for the afternoon session on collection management. For those able to attend only a single session the enrollment fee is $15 which includes course materials and lunch. A 20% discount on registration fees are offered attendees who are members of the American Association of Medical Assistants. The courses are certified for CEU (Continuing Education Units) by the AAMA. Priority for enrollment will be given to persons who attend the full day. Physicians should plan now to enroll their office staff in both the morning and afternoon sessions. Tuition fees paid by the physician are a deductible business expense. Enrollment forms will be mailed to physician's offices during January.



Once More the British

The Royal Academy of General Practitioners in London in September put on a program for

Proceedings of
The House of Delegates



120th Annual Meeting
October 25-29, 1976

120th ANNUAL MEETING HAWAII MEDICAL ASSOCIATION

The annual meeting for the one hundred and twentieth year of coporate existence of the Hawaii Medical Association was held in Honolulu in 1976. The following program was presented.

The New Frontier of Immunology, Part I: Basic Concepts
Eugene M. Lance, M.D.
Douglas Vann, Ph.D.
Ronald W. Gillette, Ph.D.

Impact of Recent Immigrants on Infectious Disease Patterns in Hawaii Part I: Leprosy, Tuberculosis, Measles and Rubella
Scott B. Halstead, M.D.
Olaf K. Skinsnes, M.D., Ph.D.
Kirsten Vennesland, M.D.
Ned H. Wiegenga, M.D.

The Increasing Role of Gastrointestinal Endoscopy
Gary A. Glober, M.D.
Takakazu Fukumura, M.D.
W. Dawson Durden, Jr., M.D.
Robert A. Rose, M.D.

Dietary Fiber and Diseases of Affluence
Denis P. Burkitt, M.D.

Stresses of and Coping with Travel Part I: Jet Lag and Sleep Disturbances
John F. McDermott, Jr., M.D.
Charles I. Barron, M.D.
Richard Markoff, M.D.

Diagnosis and Treatment of Parasitic Diseases Part I: Discussion on Diagnosis and Treatment of Intestinal Parasites of Man
Wasim A. Siddiqui, Ph.D.
Kevin M. Cahill, M.D.
Wayne R. McKinny, M.D.

The Claudicator: Medical, Surgical and Radiological Considerations
Thomas J. Whelan, Jr., M.D.
Robert L. Kistner, M.D.
Donald C. Nickon, M.D.
Irwin J. Schatz, M.D.

The New Frontier of Immunology Part II: Immunogenetics and Infectious Disease
Eugene M. Lance, M.D.
Fritz Bach, M.D., Ph.D.
Scott B. Halstead, M.D.

Impact of Recent Immigrants on Infectious Disease Patterns in Hawaii Part II: Toxoplasmosis, Salmonelloses, Cytomegalis Inclusion Disease
Wasim A. Siddiqui, Ph.D.
Sidney Gaines, Ph.D.
Nyven J. Marchette, Ph.D.
Gordon Wallace, D.V.M.

Disease Patterns in Migrating Populations Part I: Gastrointestinal and Biliary Tract Diseases
Gary A. Glober, M.D.
Charles S. Judd, Jr., M.D.
Masao Maeshiro, M.D.
Guan Bee Ong, M.D.

Food Fads and Diets
Sheldon Margen, M.D.

Stresses of and Coping with Travel Part II: Tourism and the Tourist: Psychological Problems
John F. McDermott, Jr., M.D.
Linda Alexander, Ph.D.
Bernice E. Coleman, M.D.
Jon Streltzer, M.D.

Diagnosis and Treatment of Parasitic Disease Part II: Discussion, Diagnosis, and Treatment of Blood and Tissue Parasites
Wasim A. Siddiqui, Ph.D.
Kevin M. Cahill, M.D.
Wayne R. McKinny, M.D.

The Role of Splenectomy in Hematologic Disease
C.L. Gulbrandsen, M.D.
Ben Lin Hom, M.D.
Robert W. Wilkinson, M.D.

The New Frontier of Immunology Part III: Transplantation and Immunotherapy of Cancer
Eugene M. Lance, M.D.
Noboru Oishi, M.D.
Livingston M.F. Wong, M.D.
Benjamin L. Gordon, M.D.

Drugs of the Decade: New Antibiotics and Prostaglandins
Vincent S. Aoki, M.D.
Steven J. Berman, M.D.
Santosh D. Sharma, M.D.

Disease Patterns of Migrating Populations Part II: Cardiovascular Disease
Danelo R. Canete, M.D.
Ernest K.H. Lee, M.D.
George G. Rhoads, M.D.
Katsuhiko Yano, M.D.

Diseases of the Tropics
Kevin M. Cahill, M.D.

Stresses of and Coping with Travel Part III: Preparing for the Trip
Scott B. Halstead, M.D.
William G. Baldwin, M.D.
Charles I. Barron, M.D.
Sheldon Margen, M.D.

Pulmonary Function: The Evaluation
Russell Carlson, M.D.
F.W. Cheney, Jr., M.D.
Lee R. Joyner, M.D.
Paul M. Stevens, M.D.

Thromboembolism
Irwin J. Schatz, M.D.
C.L. Gulbrandsen, M.D.
Robert L. Kistner, M.D.
Clifford J. Straehley, M.D.

Alimentation and Hyperalimentation: When, Where, and How
J. Judson McNamara, M.D.
Sheldon Margen, M.D.
John F. Balfour, M.D.
Peter Halford, M.D.
Wilfred T. Tashima, M.D.

Drugs of the Decade: Levamisole and Other Promising Drugs
Vincent S. Aoki, M.D.
Benjamin L. Gordon, M.D.
Yoshitsugi Hokama, Ph.D.
Melvin W. Balk, D.V.M.

Disease Patterns in Migrating Populations, Part III: Carcinoma
Grant N. Stemmerman, M.D.
Denis P. Burkitt, M.D.
Masao Maeshiro, M.D.
Guan Bee Ong, M.D.
Charles S. Judd, Jr., M.D.

Influenza: The Last Unconquered Pandemic Disease of Man
Alan Granoff, Ph.D.

Stresses of and Coping with Travel Part IV: Man and the Sea
Frank Tabrah, M.D.
Edward Beckman, M.D.
William P. Jones, M.D.
Benjamin B.C. Young, M.D.

Pulmonary Function: The Management of Insufficiency
Russell Carlson, M.D.
F.W. Cheney, Jr., M.D.
Lee R. Joyner, M.D.
Paul M. Stevens, M.D.

Arthritis
Melvin H. Levin, M.D.
Eugene M. Lance, M.D.
Roger I. Ogata, M.D.

HAWAII MEDICAL ASSOCIATION—COMMITTEE STRUCTURE FOR 1976

COMMISSIONS

Medical Education Winfred Y. Lee
Internal Affairs R. Varian Sloan
Peer Review Ann B. Catts
Public Health Roy Kuboyama
Interprofessinal & Public Affairs Rowlin L. Lichter
Health Service and Care Douglas B. Bell II
Medical Services William F. Moore, Jr.
Legislation George Goto
Cancer Grover H. Batten

Bureau Of Research And Planning

William E. Iaconetti, Chairman (1977) (Maui)
Claude V. Caver (1976)
Herbert Y.H. Chinn (1978)
William W.L. Dang (1977)
Fred I. Gilbert (1976)
Lawrence H. Gordon (1976)
Winfred Y. Lee (1978)
John J. Lowrey (1978)
Wilbur S. Lummis(1976)
John F. Morris (1976)
Richard Omura (1977)
Theodore T. Tomita (1978)
Tadao Nagashima (1978) (Hawaii)
Albert Ley (1976) (Kauai)

Bylaws and Parliamentary

Harry L. Arnold, Jr.
Douglas B. Bell II
Cesar B. DeJesus
Sigdiam Lim
Desmond Wong (Hawaii)
Robert Berry (Kauai)
R. Varian Sloan, Commissioner

Cancer Committee

Paul T. Condit, Chairman
Grover Batten
R.K. Blaisdell
Carl Boyer
Thomas Burch
Paul DeMare
Kendall Early
F.V. Elizaga
Gary Glober
Norman Goldstein
R. Guerrero
Reginald Ho
Edward Jim
Robert Jim
Christian Gulbrandsen
ElmerJohnson
John Keenan
Roy Kuboyama (Commissioner)
Thomas Lau
Richard K.C. Lee
James Lumeng
Francis Oda
Noboru Oishi
Quintin Uy
Robert Wilkinson
Manas Ghosh (Hawaii)
Clifford Moran (Maui)
Jose Romero (Maui)

Cancer Commission

Grover Batten (1977) (HMA), Chairman
Carl Boyer, Jr. (1976) (Cancer Society)
Christian Gulbrandsen (1978) (University of Hawaii)
Elmer Johnson (1978) (Cancer Society)
Audrey Mertz (1976) (Department of Health)
Noboru Oishi (1977) (University of Hawaii)
Verne Waite (1978) (Department of Health)
Drake Will (1976) (Hawaii Medical Association)
Tom Burch, Project Director, ex-officio, non-voting

Chronic Illness

L. Clagett Beck, Chairman
Doris Jasinski
Roy Kuboyama (Commissioner)
James Lumeng
Willard Miyahira
Shozo Ogawa
Arnulfo Diaz (Kauai)

Communicable Disease

Franklin S.H. Young, Chairman
Samuel Allison
Steven Berman
Donald Char
L.T. Chun
Roy Kuboyama (Commissioner)
Robert Latta
Roscoe Pebley
John H. Peyton
Francis Pien
Kirsten Vennesland
Ronald Hattis (Kauai)

Community Health Care

Claude V. Caver, Chairman
Douglas Bell, II (Commissioner)
Sharon Bintliff
Donald Char
H.H. Chun
George Chung
Cesar DeJesus
Gene Doo
Richard Fardal
Fred Gilbert
Mary Glover
Charles Judd, Jr.
Benjamin Lambiotte
John LeSar
John Lowrey
James Lumeng
Paul McCallin
Rodman Miller
George Mills
William Moore
John Morris
Shigeo Natori
Noboru Oishi
John Peyton
Frederick Reppun
Marco Rizzo
George Starbuck
Kazuo Teruya
Igancio Torres
Kenneth Hughes (Hawaii)
James Mayer (Hawaii)
Alexander Miles (Hawaii)
Arch Wigle (Hawaii)
David Elpern (Kauai)

Convention

Thomas J. Whelan, Jr., Chairman
Gary A. Glober
Doris Jasinski
Ivar J. Larsen
John McDermott
R. Varian Sloan (Commissioner)
Frank Tabrah
Herbert Uemura

Crippled Children

Jordan Popper, Chairman
Argyl Bacon
Sharon J. Bintliff
Salvador Cecilio
Robert DiMauro
Gene Doo
Sherrel Hammar
David Kimura
Allan Kunimoto
Roy Kuboyama (Commissioner)
Ivar Larsen
Walter S.L. Loo
Walton Shim
V.M. Briley (Maui)
Marion Hanlon (Maui)
Richard West (Maui)
Arnold Nurock (Kauai)

Disaster

John W. Edwards, Jr., Chairman
Douglas Bell, II (Commissioner)
John Balfour
Edward Boone
William Hammon
Martha Hefley
Robert Lindberg
Joseph McNamara
Robert Oishi
Raymond Taniguchi
Livingston Wong
James Mayer (Hawaii)
Richard West (Maui)
Jeffrey Goodman (Kauai)

Economic Evaluation & Adjustment Committee

Chew Mung Lum, Chairman
James Mertz
Rodman B. Miller
William Moore
John Morris
J.I. Frederick Reppun
John Watson
Henry Yokoyama
William E. Iaconetti (Maui)
Patrick Cockett (Kauai)

Emergency Medical Services

Calvin C.J. Sia, Chairman
Paul Cook (Hospital Association of Hawaii)
David Eith (Hawaii Medical Association)
Dawson Mills (Department of Health)
Stanley Saiki (Hawaii Medical Association)
Thomas Chang, City & County of Honolulu, ex-officio nonvoting
H. Tom Thorson, Executive Director, Hawaii Medical Association, ex-officio nonvoting

Fee Survey

Maurice W. Nicholson, Chairman
John E. Edwards, Jr., Vice-Chairman
Robert C. Bell
Murray Berger
Steven Berman
Edward L. Chesne
John Corboy
Raymond DeHay
David Eith
George Ewing
Victor Hay-Roe
George Henry
Allan Izumi
Calvin Kam
Gail Li
Rowlin Lichter
Carl Lum
William Moore, Jr. (Commissioner)
L.Q. Pang
Bernard Scherman
Werner G. Schroffner
Stephen Tenby
Thomas Teruya
Jerome L. Tucker
Robert Hamblin (Kauai)
Ben Hur (Hawaii)

Finance

Grover H. Batten, Chairman
Marcelino Avecilla
Albert Chun-Hoon
John W. Edwards
Elmer Johnson
Richard Omura
Walter W.Y. Chang, Treasurer, Honolulu County
Michael Cicero, Treasurer, Kauai County
Russell Stodd, Treasurer, Maui County
Alexander Miles, Treasurer, Hawaii County

Health Facilities

Sakae Uehara, Chairman
Masaru Koike
Rowlin Lichter (Commissioner)
John Lowrey
Rodman Miller
Ronald Moore
Shigeo Natori
E. Lee Simmons
Benjamin Tom
Lawrence Wong
William James (Maui)
Charles Custer (Kauai)

Health Manpower

H.H. Chun, Chairman
Douglas Bell, II (Commissioner)
Gerald Faulkner
Robert Lindberg
Robert Nordyke
Walter Quisenberry
Calvin Sia
Frank Tabrah
Kenneth Fujii (Kauai)

Interprofessional Relations

George Schnack, Chairman
Samuel Allison
Albert Chun-Hoon
Edwin R. Curphey
Kendall Early
Calvin Kam
Eugene Lance
Rowlin Lichter (Commissioner)
Herbert Luke
John Morris
Robert Thune
Rex Couch (Kauai)

Intraprofessional Liaison

William Hindle, Chairman
Frederick Fong
Rowlin Lichter (Commissioner)
Frank J. Puerta
Gildo Soriano
Robert Thune
David Sears (Kauai)

Legislation

George Goto, Chairman (Commissioner)
Edwin B. Adams
Richard K. Blaisdell
Clarence F. Chang
Robert Clingan
Richard Dang
Richard Fardal
William Hindle
Leonard B. Howard
John Keenan
Roy Kuboyama
Richard K.C. Lee
Worldster Lee
B.R. Mehta
William Moore
Herbert M. Nakata
Roger I. Ogata
J.I. Frederick Reppun
George Schnack
Roy Smith
Robert Thune
Neal Winn
Sau Ki Wong
Marion Hanlon (Maui)
Walter S.L. Loo (Hawaii)
Helen Percy (Maui)
Sakae Uehara (Maui)
Robert Berry (Kauai)
Verne Waite (DOH)

Maternal and Perinatal Mortality

George Goto, Chairman
Robert Allin
Ronald Berman
Sharon Bintliff
Ann Catts (Commissioner)
Andre Choan
Gordon Ing
F.C. Li
Gail Li
Paul McCallin
Wayne McKinney
Carl Morton
Herbert Nakata
Shigeo Natori
Roy Niimi
John Ohtani
Gordon Ontai
Thomas Oshiro
Richard Sakimoto
Norman Sato
Walton Shim
George Shimomura
Roy Smith
Francis Soon
John Spangler
Wayne Takemoto
Francis Terada
Thomas Teruya
Theodore Tseu
Herbert Uemura
James Wong
Keijiro Yazawa
Franklin Young
Joseph Young
Lockwood Young
Lawrence Allred (Maui)
Denis Fu (Maui)
Clifford Moran (Maui)
Hoon Park (Hawaii)
William Patterson (Maui)
Wolfgang Pfaeltzer (Maui)
Patrick Aiu (Kauai)

Medical Education

Winfred Y. Lee, Chairman (Commissioner)
Vincent Aoki
Murray Berger
Richard K. Blaisdell
George Bolian
Nadine Bruce
Ann B. Catts
Benjamin Chang
H.H. Chun
Albert Chun-Hoon
Frederick Fong
Edgar Ho
P.W. Hong
Charles Judd
Roy Kuboyama
Ivar Larsen
J.I. Frederick Reppun
Clifford Straehley
Patrick Walsh
John Watson
Michael Cicero (Kauai)

Medical Malpractice, Ad Hoc

Albert Chun-Hoon, Chairman
Ann B. Catts
John Kim

Winfred Y. Lee
John J. Lowrey
Chew Mung Lum
Maurice W. Nicholson
Alan Pavel
J.I. Frederick Reppun
Patrick Walsh
Egbert H. Fell (Hawaii)
Peter Kim (Kauai)
Kenneth McCollum (Maui)

Peer Review

Chew Mung Lum, Chairman
Robert D. Bart, Jr.
Ann Catts (Commissioner)
Frank E. Ceccarelli
Victor Hay-Roe
L.Q. Pang
R. Varian Sloan
Clifford J. Straehley
Mitsuo Tottori
E. Duane Beringer (Maui)
Manas Ghosh (Hawaii)
Robert Berry (Kauai)

Pharmacy

Daniel D. Palmer, Chairman
Vincent S. Aoki
George Goto (Commissioner)
Bert Lum
Yonemichi Miyashiro (Kauai)

Professional Liability

Bernard W.D. Fong, Chairman
Ann Catts (Commissioner)
Clifford Chock
John W. Edwards
Raymond H. Fujikami
George Goto
Gail G.L. Li
John Lowrey
Chew Mung Lum
Gabriel Ma
Mor McCarthy
John Watson
John N. Withters (Maui)
George Bracher (Hawaii)
Peter Kim (Kauai)

Public Affairs

Rowlin Lichter, Chairman
(Commissioner)
Claude Caver
Doris Jasinski
Virgil Jobe
Robert May
Thomas McCowan
James Penoff
Ronald Pion
Margaret Rose
George Schnack
Ramon Sy
Robert Thune
Ignacio Torres
Peter Claremont (Kauai)

Public Safety

Truett V. Bennett, Chairman
Martha Lou Hefley
Virgil Jobe
Roy Kuboyama
Michael J. McCabe
Frank J. Puerta
John S. Spangler
Maurice Giraudier (Kauai)

Publications

William F. Moore, Jr. Chairman
Harry L. Arnold, Jr.
Grover Batten
Douglas Bell, II
Ann B. Catts (Commissioner)
Marion Hanlon
Doris Jasinski
Winfred Y. Lee
Frank McDowell
J.I. Frederick Reppun
John Watson
Henry Yokoyama
Thatcher Magoun (Kauai)

School Health

Roy Kuboyama, Chairman
Fernando Atieza
Donald Char
Robert Clingan
Sherrel Hammar
Robert Nemechek
Roy Niimi
Michael Okihiro
John H. Peyton
S.H. Tenby
Ann B.H. Yee
Franklin S.H. Young
Marion Hanlon (Maui)
Gonzalo Geroso (Kauai)

Site Committee

Grover Batten, Chairman
Douglas Bell, II
Albert Chun-Hoon
William Dang

Sports Medicine

Michael Okihiro, Chairman
Edward Kagihara
Albert Kong
Roy Kuboyama (Commissioner)
George Mills
Robert Nemechek
Raymond Taniguchi
Richard Tesoro
Franklin Young
Thomas Grollman (Kauai)

Substance Abuse

Donald Char, Chairman
Benjamin Chang
John Corboy
Gladys Fryer
Robert Latta
James Lumeng
Audrey Mertz
G.W. Starbuck
Robert Thune
Neal Winn
Gary MacGregor (Kauai)

TV-Radio Committee

Henry Yokoyama, Chairman
Samuel Allison
Claude Caver
John Corboy
Robert Flowers
Rowlin Lichter (Commissioner)
Sigdian Lim
George Monlux, Jr.
Ronald Pion
E. Lee Simmons
George Suzuki
Theodore Tseu
Rex Couch (Kauai)
Helen Percy (Maui)

Women's Auxiliary

Jerome L. Tucker, Chairman
Philip M. Corboy
Lolita N. Quintal
Joan Takeuchi (Kauai)

Workmen's Compensation

Raymond H. Fujikami, Chairman
Francis T.C. Au
Robert C. Bell
Edward L. Chesne
Raymond DeHay
Raymond Duscendschon
Calvin C.M. Kam
David Y. Kimura
Worldster Lee
Rowlin Lichter
Robert May
William Moore (Commissioner)
L.Q. Pang
Kosta Stojanovich
Edward Underwood (Maui)
Walter S.L. Loo (Hawaii)
W. Wallace Greene (Kauai)

Ad Hoc Committee on Building Management

William W.L. Dang, Chairman
Calvin C.J. Sia
Douglas B. Bell II
Ann B. Catts
Clifford Moran (Maui)
Kenneth Hughes (Hawaii)
Thatcher Magoun (Kauai)
Grover H. Batten, ex-officio

Ad Hoc Committee on Diabetes

Winfred Y. Lee, Chairman
John Kim
Terry Wong
Werner Schroffner
Fred Gilbert
Willard Miyahira
Ralph Beddow
Irwin Schatz
Ronald Moore

Index to the 1976 Proceedings of the House of Delegates

Special Reports

County Society Reports
- Honolulu 406
- Maui 406

Officers
- President 384
- Secretary 385
- Treasurer 394

Appointees
- Editor, HAWAII MEDICAL JOURNAL 389
- Legal Counsel 383
- Mabel L. Smyth Board 390
- Legislative Counsel 382

Additional Reports
- AMA Delegate 405
- Cancer Center of Hawaii 401
- Community Research Bureau 391
- Executive Director 386
- HAMPAC 386
- President, H.M.A. Auxiliary 390
- Hawaii Foundation For Medical Care 384
- Pacific PSRO 384

Commission Reports

- Continuing Medical Education 389
- Peer Review 387
- Legislation 382
- Medical Services 385
- Internal Affairs 388
- Public Health 394
- Interprofessional and Public Affairs 402
- Health Services and Care 402

Committee Reports

- Building Management 390
- Bureau of Research and Planning 391
- Cancer 394
- Cancer Commission 405
- Chronic Illness 401
- Communicable Disease 401
- Community Health 402
- Continuing Medical Education 388
- 1976 Convention 388
- 1977 Convention 388
- Disaster 402
- Economic Evaluation and Adjustment 385
- Election 407
- Fee Survey 386
- Oahu Emergency Medical Services 403
- Health Manpower 402
- Legislative 382
- Long Range Planning 391
- Maternal and Perinatal Mortality Study 387
- Medical Malpractice 383
- Nominating 407
- Peer Review 387
- Pharmacy 382
- Professional Liability 387
- Publications 388
- School Health 401
- Search 394
- Sports Medicine 401
- Task Force on Diabetes 405
- TV-Radio 402
- Workmen's Compensation 386

Resolutions

- No. 1—Emergency Medical Services Program . 405
- No. 2—The Dang Plan 391
- No. 3—Act 219 386
- No. 4—Support of the Hawaii Medical Library, Inc. 391
- No. 5—Act 219 Amendments 387
- No. 6—Amendments to Act 219 387
- No. 20—The Office of Vice President 391

PROCEEDINGS OF THE HOUSE OF DELEGATES

120th Annual Meeting of the Hawaii Medical Association

The first session of the House of Delegates meeting was called to order by President William W.L. Dang on Wednesday, October 27, 1976, at 1:30 p.m. in the Pacific Ballroom at the Ilikai Hotel. Dr. R. Varian Sloan called the roll. Present were Drs. Calvin C.J. Sia, Winfred Y. Lee, Grover H. Batten, Douglas B. Bell II, Thatcher Magoun, Clifford F. Moran, Verne L. Adams, Ann B. Catts, Albert C.K. Chun-Hoon, George Goto, Rowlin Lichter, Carl H. Lum, J.I.F. Reppun, Arnold Siemsen, Peter Kim, Sakae Uehara, George H. Mills, William E. Iaconetti, John J. Lowrey, Rodney T. West, Marion Hanlon, Denis Fu, Jose Romero, Burt Wade, Ernest Bade, Ruben Casile, R.P. Wipperman, Ralph M. Beddow, Vincent S. Aoki, Sharon Bintliff, Carl W. Boyer, Danelo R. Canete, Jeanette H.J. Chang, Walter W.Y. Chang, Virgil R. Jobe, Thomas Kobara, W. Dawson Durden, John W. Edwards, Elmer C. Johnson, Paul Condit, Charles S. Judd, Edward K. Kagihara, John P. Watson, Roy Kubovama, Andrew L. Morgan, Michael Okihiro, Alan Pavel, Thomas Whelan, Shigemi Sugiki, Patrick Walsh, Neal Winn, Eugene G.C. Wong, Leonard Howard, Victor M. Mori, and David Sakuda.

Dr. John H. Budd, President-elect of the American Medical Association, was invited to address the House of Delegates. He stressed the importance of physician involvement in medical association activities and the need to be aware of the role of the AMA and its accomplishments during the past few years.

The minutes of the 119th Annual Meeting as published in the December 1975 issue of the HAWAII MEDICAL JOURNAL were approved as published.

Dr. Dang announced to the House that a suit had been filed by HMA on October 27 in the First Circuit Court relative to the mandatory requirement for professional liability insurance for licensure.

The reports of the President, Secretary, Treasurer and component societies were included in the delegates handbook and referred as indicated. The resolutions were also assigned to reference committees.

Reference Committees were appointed as follows: **Miscellaneous Business** — George Goto (Chairman), Ann B. Catts, Andrew L. Morgan, Denis Fu, and Burt Wade; **Public Health** — Sakae Uehara (Chairman), Eugene G.C. Wong, Roy Kuboyama, and Charles S. Judd, Jr.; **Peer Review and Finance** — John Watson (Chairman), Neal Winn, Vincent Aoki, Ernest Bade, Marion Hanlon, J.I.F. Reppun.

* * * * *

The Reference Committees were in session October 27 beginning at 2:30 p.m.

* * * * *

The second session of the House of Delegates was called to order on Friday, October 29, 1976, at 9:30 a.m. Delegates Canete, Johnson, Sugiki, and Walsh were absent the second day.

* * * * *

Miscellaneous Business Reference Committee

COMMISSION ON LEGISLATION

HOUSE ACTION: Adopted

Legislative Committee

The 1976 Session of the Eighth State Legislature was a particularly stormy one as it related to medical professional liability. The ad hoc committee on Medical Malpractice is to be commended for doing yeoman's service in carrying the wishes of the Association to the halls of the Legislature. It is unfortunate that the majority of the members of the medical profession did not rally behind its leadership while the bills relating to medical professional liability were being considered by the legislators. The difficult task of steering thru the maze of the legislature was greatly alleviated by our legislative counsel, Mr. Kazuhisa Abe, who is a former justice of the State Supreme Court and a former president of the State Senate.

The following bills relating to medicine were passed by the Eighth State Legislature 1976:

(1) HB 2700-76, CD 1 relating to medical professional liability. This bill and related matters are reported in full by the ad hoc committee on medical malpractice chaired by Dr. Albert Chun-Hoon.

(2) SB 2121-76, CD 1 relating to payment for medical and professional health care services under public assistance programs up to 100% of the 75th percentile of the usual and customary fees. Dr. Roy Kuboyama with the assistance of the Physician's Action Group was instrumental in having this bill enacted.

(3) SB 2371, CD 1 grants to minors who are or who have been married all the rights, duties, privileges and responsibilities provided under civil law to a person who has reached the age of majority.

(4) HB 3248, CD 1 places administrative control of the council on developmental disabilities under the Department of Health.

(5) SB 251 insures that the Hawaii Tumor Registry will receive reports of cancer diagnosed or treated from all hospitals and skilled nursing homes.

(6) SB 1899-76, HD 1 establishes the office of children and youth under the governor.

(7) SB 2294, CD 1 outlines public participation in SHCC under PL 93-641.

(8) SB 2709, CD 1 amends the mental health law re commitment procedures.

There were funds appropriated for the following: to the Board of Medical Examiners for implementation of HB 2700; to DSSH to implement SB 2121; to DSS for group psychotherapy; to Children's Hospital for construction; to the Poison Control Center operation; to the Department of Health for support of the bilingual health aid program and for a statewide school health program.

Budget Request:

Legislative Counsel	$7,500.00
Promotional Activities Related to Medical Professional Liability	1,500.00
Today's Health	300.00
Miscellaneous	400.00
Total	$9,700.00

Recommendations:

(1) That the budget of the Legislative Committee be approved.

(2) That the invaluable services of Mr. Kazuhisa Abe be acknowledged and that his services be retained for the next legislative session.

Pharmacy Committee

The Pharmacy Committee, under the chairmanship of Dr. Daniel Palmer, met on one occasion to review various legislative bills relating to generic substitution of drugs. Testimony was prepared for various legislative hearings and no further action was taken by the legislature.

GEORGE GOTO, M.D.

Legislative Counsel

HOUSE ACTION: Filed

Your legislative counsel was retained primarily for the

purpose of having the State Legislature enact a medical malpractice law as favorable to the medical profession as possible.

House Bill No. 2700-76 entitled "A Bill for an Act Relating to Medical Professional Liability" was selected for the enactment of the medical professional liability law. Prior to the commencement of the Eighth State Legislature, your counsel attended several meetings called by the Ad Hoc Committee, appointed by the Director of Regulatory Agencies, for the purposes of testing a consensus bill relating to medical professional liability. Your counsel also attended several meetings with the various committees of the Hawaii Medical Association.

Following the commencement of the Eighth State Legislature, your counsel kept in constant contact with both the Speaker of the House and President of the Senate. After learning that the Bill was assigned to the House Committee on Consumer Protection and Commerce and the Senate Judiciary Committee, your counsel contacted Representative Dennis Yamada and Senator Donald S. Nishimura, chairmen of the respective committees. Your counsel also made appointments with every member of the House Committee and informed them of the critical situation faced by Hawaii's physicians.

After the House Committee reported out H.B. No. 2700-76, the Association found that some provisions of the proposed Bill were not desirous. One of the provisions objected to by the Hawaii Medical Association and several physicians was the requirement that prior to the issuance of a license to practice medicine, a doctor would be required to provide a bond or security in the sum of $100,000. After a conference with the Association's Legislative Committee, your counsel was successful in having Representative Jack Suwa, Chairman of the Finance Committee, call a public meeting so that members of the Hawaii Medical Association could state their reasons why H.B. No. 2700-76, as presented to the Finance Committee, should be amended.

Subsequent to the passage of the Bill in the House, your counsel concentrated his efforts on contacts in the Senate. He had several conferences with Senator Nishimura and his attorney, Wallace Ching. Your counsel also met with each member of the Senate Judiciary Committee and tried to gain their support to have the House version of the Bill changed as desired by the Hawaii Medical Association. Your counsel and members of the Association's Legislative Committee met with the minority members of the Senate Judiciary Committee. The meeting was most encouraging in that the Republican members agreed to fight for the changes we desired.

Your counsel attended all of the public hearings held by the Judiciary Committee. When the members of said Committee were deadlocked as to certain points of the Bill, your counsel suggested the implementation of several amendments. Two of these amendments were adopted. Although members of the Association's Legislative Committee and your counsel argued vehemently for the elimination of the requirement of a physician to provide a bond or security, we were unsuccessful.

From time to time when Mrs. Becky Kendro called your counsel for advice on other pending bills, your counsel so advised her. Also, when members of the Hawaii Medical Association wanted to meet with legislators your counsel tried to arrange for such appointments.

Then at the request of Dr. Roy F. Kuboyama, your counsel attended a meeting called by Representative Kathleen Stanley, Chairman of the House Committee on Public Assistance and Human Services concerning physicians' fees with the Medicaid program. Your counsel suggested an amendment to the Bill and the suggestion was accepted.

All in all, your counsel feels that the Eighth State Legislature enacted House Bill No. 2700-76 generally satisfactory to the Hawaii Medical Association. Although the Association is not totally in favor of the provisions of the Bill which became Act 219, Session Laws of Hawaii 1976, I feel it is incumbent upon the Association to bring to the attention of each legislator, the shortcomings of the Act so that necessary amendments may be enacted. The Hawaii Medical Association, therefore, should be ever diligent in working towards the enactment of laws which would benefit the medical profession and which would improve the medical care and services to the people of Hawaii.

The success of the legislative program of the Hawaii Medical Association was due to the conscientiousness and hard work of its members, staff, Legislative Committee, chairmen of its various subcommittees, Dr. George Goto, and Mrs. Becky Kendro.

Thank you for giving me the opportunity to work with you and for you.

KAZUHISA ABE

Legal Counsel

HOUSE ACTION: Filed

This report covers the 13-month period September 1, 1976 to September 30, 1976, during which your legal counsel attended the 1975 meetings of the Caucus of Oahu Delegates and the House of Delegates and several Council meetings, and handled administrative calls, correspondence, and matters for the Association as required by your staff and officers.

The subjects on which we conferred included questions relating to and review of the Hawaii, Maui and Kauai Bylaws with reference to their compliance with due process; doing background work on the proposed medical malpractice legislation; drafting and conferring on a proposed peer review requirement by the principal professional liability insurance carrier; doing research and expressing opinions on EMS and PSRO program questions; review of the effect of amendment to the Medical Malpractice Act; review and expressing opinions relating to Hawaii Committee Peer Review procedures; and review of Honolulu County Medical Society Medical Practice Committee's procedures; and general administrative questions.

Major projects, clearly not repetitive, involved an evaluation and opinions of the "Dang Plan" with actuaries and accountants; and involvement in the process of acquiring the 320 Ward Avenue building. There has been and there will be ongoing involvement in operational problems relating to leases of portions of the 320 Ward Avenue building.

At this time there are two unfinished problems which the office of legal counsel is involved in: (1) The amendments to the Pension Plan; and (2) A continuing involvement in a court test of the compulsory insurance requirements (financial responsibility provisions) of the medical malpractice legislation (HB 2700-76, Act 219).

Your legal counsel has no recommendations and has no budget request relating to general matters. Budget request for legal counsel services with reference to the two pending matters are the subject of other committee reports.

V. THOMAS RICE

Medical Malpractice, Ad Hoc

HOUSE ACTION: Adopted as follows:

The Ad Hoc Committee on Medical Malpractice met and presented the following recommendations to the Council of the HMA, all of which were approved. We recommend that the House of Delegates reaffirm the recommendations:

(1) That the ad hoc committee on Medical Malpractice be continued and that they pursue amendments to the malpractice law in the 1977 State Legislature as recommended in Item (2).

(2) That the committee continue to pursue changes in the legal doctrines section of the malpractice law to include: statute of limitations change for minors, definition of the doctrine of res ipsa loquitur, collateral source rule, periodic payment of awards, and reduction of contingency fees.

(3) That the HMA submit a list of nominees for the Patient Medical Conciliation Panels to the Board of Medical Examiners on an annual basis. The nominees will be elected by the county medical societies. That the HMA encourage, together with the Hawaii Bar Association, the Director of Regulatory Agencies to sponsor a semi-

nar for orientation on procedures and purposes of conciliation panels for the 25 physicians and 25 attorneys who are selected as panelists.

(4) That the HMA oppose the section of the law requiring insurance for licensure and that the HMA strongly consider filing suit to test the constitutionality of such a law.

(5) That each county medical society arrange for an election process in their bylaws for nominations to the Board of Medical Examiners. These nominations should be submitted via the HMA.

(6) That the county societies define their highest Peer Review Committee if they have not already done so.

(7) That the next committee on malpractice continue to work on a voluntary arbitration agreement that could be used by individual physicians.

(8) That the HMA study the feasibility of a self-insurance company and that the final decision rest with the House of Delegates and that the House of Delegates reaffirm the decision made by the Council at its meeting of September 10 for the payment of up to $5,000 to F.B. Hall and Company contingent upon the issuance of a solicitation permit.

(9) HMA should favor legislation that physician members on the Medical Conciliation Panels be compensated for their services and the expenses be borne by the appropriate governmental agency.

The ad hoc committee requests support of the budget requests for legislative counsel ($7,500.00), for the legal fees to test the constitutionality of Act 219, and to pursue the formation of a self-insurance company.

ALBERT C.K. CHUN-HOON, M.D.

Pacific PSRO

HOUSE ACTION: Filed

Although the Pacific PSRO, Inc. is independent of the Hawaii Medical Association, it is felt that an update of the activities of this federally funded quality assurance program needs to be made to the Hawaii Medical Association as the organization representing the clinicians in the State of Hawaii.

During 1976, the planning for a conditional phase of the PSRO was completed, and on July 1, 1976, the Pacific PSRO, Inc., was officially designated by DHEW as the conditional PSRO for our area. For the 12 months, July 1, 1976 through June 30, 1977, the Pacific PSRO was awarded funds of $339,039. The Pacific PSRO anticipates the phasing-in of all short stay hospitals in the State of Hawaii under official PSRO review by April 1, 1977. The Pacific PSRO at the present time is engaged in the evaluation and selection of a data processor for PSRO activities and in the recruitment of our head medical care review coordinator.

The Pacific PSRO has selected a Review Committee, a Criteria Committee, and the Advisory Group to the Pacific PSRO. Official PSRO review has been instituted in three hospitals on Oahu.

Federal constraints still continue to alter the effectiveness of the Pacific PSRO (as they do other PSROs across the country). However, it is hoped that continued communication and "trust" by physicians and institutions in our area will prevail so that the goals of quality assurance can be achieved.

The Pacific PSRO wants and needs the active involvement of practicing physicians. It is our desire that the HMA, representing the practicing physicians of this state, continue to support the ongoing programs to be developed under PSRO and especially the needed programs in continuing medical education.

WINFRED Y. LEE, M.D.
President

Hawaii Foundation For Medical Care

HOUSE ACTION: Adopted

The House of Delegates in 1975, passed a resolution requesting the Hawaii Foundation for Medical Care (HFMC) to explore the feasibility of the HFMC to develop a statewide Health Maintenance Organization (HMO) program for Hawaii.

The HFMC Board of Trustees met to discuss and evaluate this task. The Board felt that it needed more information relative to the requirements of an HMO, including a discussion of the law itself. The Board asked that all pertinent material relative to HMO's be gathered and disseminated to the Board members.

At this time, no definitive action has been decided upon regarding the feasibility of the HFMC becoming a developer of a statewide HMO in Hawaii. It is noted that major amendments to the HMO law have been enacted by our last Congress, and these amendments will need to be correlated with existing laws and regulations and then evaluated.

The insurance portion of the HFMC continues with the Roofer's Union Self-Insured Program. The Board of Trustees has considered an adjustment of the conversion factor (based on the Hawaii Relative Value Study of 1970) as the last adjustment occurred in 1972. To date, no definitive action has occurred. The HFMC staff has had a number of discussions with the Roofer's Union regarding program benefits and the possibility of an adjustment in the conversion factor for the program. The HFMC staff has continued to assist the Roofer's Program in claims review and program benefits.

Recommendations:

1. That the HFMC Board of Trustees complete its investigation of the feasibility of the HFMC-sponsored statewide HMO program;
2. That the HFMC Board of Trustees continue its evaluation of the Roofer's Union program and the need for an adjustment of the conversion factor;
3. That the Board of Trustees of the HFMC, in conjunction with the HMA Council, evaluate the role, function, and need for the HFMC and its activities;
4. That the HFMC report back to the House of Delegates at the next Annual Meeting.

WINFRED Y. LEE, M.D.

President

HOUSE ACTION: Adopted

Accomplishment and challenge have been the bywords for this year of the presidency of the Hawaii Medical Association. Accomplishment that has come out of challenge; challenge that has arisen out of accomplishment. I must say at the beginning, however, that HMA's accomplishments, and the ability and capability to meet the most difficult and trying challenges, have been possible only through the membership of the HMA and because of the efforts of the commissions and committees and the individual efforts of physicians on behalf of the association.

This year saw some joyful occurrences: for the first time in history, the American Medical Association held its clinical session of its House of Delegates in Hawaii, and it was an enlightening experience for both our physicians and for those physicians who traveled here to attend; this year saw the HMA's allotted number of delegates increase from one to two as our active membership passed the 1,000-member mark; this year, Tel-Med, the telephone service to the general public on health matters, was instituted through the cooperation and co-sponsorship of the HMSA and through the support of the Chamber of Commerce of Honolulu; this year saw the HMA move into *its* new home at 320 Ward Avenue! It is most delightful and fitting quarters for your professional association, and I urge all of you who have not had the opportunity to visit these quarters to do so and to "make yourself at home."

The purchase of our own home has, however, dictated a financial responsibility by the HMA and its membership, and, therefore, the Capital Fund Advance Plan (commonly known as the "Dang Plan"), as authorized by our House of Delegates, was implemented. This plan of members' loans to the HMA will insure HMA's ability to remain in its new home and yet, return to each member, the full amount of his loan and the

satisfaction of knowing that he has helped to "build" this home.

This building purchase and our subsequent move into it has precipitated an issue regarding the future maintenance of the Mabel Smyth Building which the HMA currently has an interest in. We are hopeful that the HMA will be able to resolve the issue.

The activities of the past Legislature of Hawaii provided some momentous events: a bill which allows our DSSH to pay providers of medical, dental, and other professional health care services their usual and customary fees up to a maximum which federal rules permit; and, of course, Act 219, commonly referred to as the medical malpractice insurance act, which has caused a great deal of concern because of some of its mandatory provisions, especially that of mandatory malpractice insurance or proof of financial responsibility. There is much activity at present in response to this Act. The HMA, and other physician groups as well, are expending much effort in trying to alleviate some of the inequities in this Act. We are encouraged in the progress we have made to date.

Our EMS project and our Hawaii Tumor Registry project, both supported by federal funds, continue to develop the areas of emergency care and of cancer research in the State of Hawaii.

The swine flu episode required much time and effort on the part of many people, including physicians, in many parts of our community. While differences of opinion exist regarding the true situation of the potential epidemic, the HMA has continued to provide direction to the physician-members.

Our annual meeting this year is exceptional. For the first time, we have instituted a system of fees for postgraduate courses in order to continue to be able to provide the physicians of this State with outstanding, high-quality continuing medical education opportunities. You will agree, I am sure, that the programs and the faculty provided at the annual meeting this year are truly excellent.

We have remained on a basis of sharing portions of staff and facilities with the HCMS; we have also, however, tried to increase our communications with and services to the other county medical societies. We have great hopes that this link with the neighbor islands will continue to grow and be strengthened.

We have accomplished much, and some things for the very first time in the history of the HMA. Much, however, remains to be done. The questions regarding the implementation and operations of the so-called HSA and the SHPDA remain unanswered, and it is up to the HMA and its physician-members to try to be aboard when the implementation occurs. We have much homework and hard work left in the area of malpractice insurance and the host of related problems and concerns. Our purchase of our new home has presented the HMA with an entirely new set of problems regarding finances and operational management of the organization. These problems we must face and meet squarely. PSRO has arrived; and while the HMA has been in close touch with its development over the past two years, the fledging has grown to maturity, and constant monitoring must be achieved over this "locally-directed" but federally-restricted program of quality assurance.

There is much that HMA can do in the years ahead without having to look for things to do. However, there is one thing that the HMA and all physicians must look at and act accordingly, and that is the image of the physician in society today. Perhaps we have said that this is not our concern, that our primary focus needs to be in our patients. No one will fault this attitude; and yet, too often, the image of physicians in the wrong light may hamper our efforts to provide the highest quality of care to our patients. We must, as physicians, become involved in not only medical matters, but community matters, for through the community, the physician can be heard.

I wish to comment on one item: Tom Thorson, our Executive Director for the past six years in the HMA (total of 13 when you include time in the HCMS), has decided that the "better part of life" has just come for him. His retirement, effective December 1, 1976, will mean the loss of a dynamic executive that has sweated and grown with our organization. His departure for the comforts of Sequim, Washington, will be felt. He goes, however, knowing that he has been a good teacher. We all bid him a fond "aloha!"

Recommendations:

Your president could possibly think of many recommendations for the organization in the coming years; however, your new leadership is undeniably capable of guiding the HMA. I only urge that you physicians become active in and supportive of YOUR HMA, for YOUR professional association will carry on and uphold the ideals of the profession.

I humbly thank you for the privilege of serving as your president this year. It has been frustrating and time-consuming, but it has also been most rewarding to this physician. My thanks could extend to many pages in listing my gratitude for the support and efforts of the officers, council members, commissioners, committee members, county presidents, and of course, the HMA staff. I only wish you to know my heartfelt thanks is here. And with their leadership, HMA will flourish.

WILLIAM W.L. DANG, M.D.

Secretary

HOUSE ACTION: Adopted with the recommendation that Dr. R. Varian Sloan's long years of service as Secretary be acknowledged with sincere gratitude from all HMA members.

The total active membership of the Association as of December 31, 1975, was 1,004, an increase of 58 compared to December 31, 1974 which was 946. The special members numbered 30, a decrease of five from the previous year. Of the 1004 active members, 123 were granted a dues waiver, an increase of 13 over the previous year.

Thirteen members died since the last annual meeting: James A. Mitchel, William N. Bergin, Leon E. Mermod, George C. Murdock, Walter M. Ozawa, Ray T. Huffman, Joseph W. Lam, Edmund Tompkins, William D. Graham, Youtaik Kim, Arthur V. Molyneux, Henry S. Dickson, Shigeru R. Horio.

By counties, the active membership was made up as follows as of December 31, 1975:

County	Active Dues Paying	Active Dues Waived	Total
Honolulu	711	99	910
Hawaii	64	14	78
Maui	68	5	73
Kauai	38	5	43
	881	123	1004

As of September 1, 1976, the active membership has decreased to a total of 953 members.

Since the last annual meeting, there have been nine Council meetings that were held as follows: November 20, 1975; December 12, 1975; and in 1976 on January 16, February 27, April 23, May 28, July 30, September 10, and October 1.

(Minutes of all Council meetings as printed in the HAWAII MEDICAL JOURNAL were included in the delegate's handbook for ratification.)

R. VARIAN SLOAN, M.D.

Commission on Medical Services

HOUSE ACTION: Adopted with the condition that the Fee Survey Committee continue with their preparation and study of a new relative value studies but that the final decision regarding publication of a new RVS be left to the Council.

The Commission on Medical Services consists of three committees: Economic Evaluation and Adjustment Committee, Fee Survey Committee and Workmen's Compensation Committee. The reports of these committees are reprinted below:

Economic Evaluation and Adjustment: The Economic Evaluation and Adjustment Committee has not held any

meetings during the past year. Discussions with the Legislature on fees for Department of Social Services clients were handled by Dr. Roy Kuboyama and the Legislative Committee.

CHEW MUNG LUM, M.D.

Fee Survey Committee: During the past year, the Fee Survey Committee has met on numerous occasions. Recently the committee has been meeting every two weeks in an attempt to finalize the new Relative Value Studies. Printing of the new fee survey book should be completed by early 1977 and new books will be distributed to the members. The budget request for 1977 is $20,000 to meet the cost of publishing a new book. This amount was budgeted last year but will not be used as the book is only now getting close to being ready for publication.

MAURICE W. NICHOLSON, M.D.

Workmen's Compensation Committee: There were no meetings held by the committee except for a joint meeting held by the Fee Survey Committee and the Workmen's Compensation Committee on September 20, 1976 with Mr. Wally Okuna and Mr. Orlando Watanabe of the Department of Labor and Industrial Relations.

The purpose of the meeting was to see if anything could be done about increasing the workmen's compensation fee schedule in light of the soaring medical professional liability insurance premiums. Although Mr. Watanabe was sympathetic to the doctor's plight, he noted there was nothing that could be done at this time as payment for medical services is strictly defined by Hawaii statute. He noted there will be another yearly increase based on the Consumer Price Index and the next major adjustment or change must be discussed in 1977, an occurrence which takes place every three years as the law is written.

Those present were urged to write to the Department of Labor regarding this matter. Discussion was also held on the adoption of the HMA Relative Value Studies and the usual and customary fee concept for workmen's compensation cases and that this would lessen the administrative problems of the State Department of Labor.

Recommendations:

(1) That the new HMA Relative Value Studies be printed and ready for distribution well in advance of the meetings to be held beginning March 1977 with the Department of Labor.
(2) Discussion and presentation of recommendation that RVS and usual and customary fee concept be adopted for Workmen's Compensation cases since it will make all procedural codes identical, ease the administrative problems of the Department of Labor and ease the paperwork of the insurance carriers and the doctors.
(3) Every doctor that knows any legislator should personally talk to him and others should write to legislators known to be friendly to medicine's cause stating the HMA's recommendation and reasons for them.

RAYMOND H. FUJIKAMI, M.D.
WILLIAM F. MOORE, M.D.
Commissioner

Executive Director

HOUSE ACTION: Filed with a vote of commendation for Mr. H. Tom Thorson for his many years of faithful service to the HMA.

This is, in a way, a farewell report. I will be retiring from active work for the HMA at the end of November.

The past year has been marked by a number of major activities, requiring new approaches and techniques. HMA now owns its home. The purchase of the building culminates many years of hopeful planning by many individuals. This, I believe, is the most far-ranging and important development of the year; its benefits will extend down the years to come.

The Pacific PSRO is an operating agency, and fortunately is under the aegis of HMA. This is as it should be. The concept of outside review by non-medical agencies is unacceptable.

The malpractice insurance matter, which developed into such a chaotic situation and is still not resolved, brought about many divisive pressures, but in the long run may meld the association into a tighter knit and more cohesive organization than ever before.

The new fiscal relationship between the HMA and the Honolulu County Society should improve the operating effectiveness of each. Our five-year tryout of the Common Fund idea gave us a lot of insight into joint financing, and I strongly recommend that the operating contract idea be given an opportunity to demonstrate its effectiveness.

The concept of a single executive for both organizations has been established as workable. Certainly the single-staff idea has been of benefit to both organizations, and it is not possible to have a single staff with two heads. I recommend the continuance of a single executive for the joint operation.

You can be proud of your staff. You are blessed with a dedicated and loyal group of people who devote their energies to programs designed to benefit the profession and the community.

The officers have given generously of their time and efforts to support and strengthen the Association and the Society, and I believe that there has never been a time when the HMA enjoyed a better standing in the community. You can be proud to be a member of the Hawaii Medical Association.

I leave your organization with some regrets at unfinished tasks but I know that no matter when departure time comes, there is always something left to do. I am confident that willing hands will carry on, and I always remember that there is no such thing as an indispensable person. God Bless you all.

H. TOM THORSON

HAMPAC

HOUSE ACTION: Adopted

Membership in the Hawaii Medical Political Action Committee (HAMPAC) reached an all time high during 1976. At the end of September there were 240 reported members consisting of 224 physicians, 13 physician spouses, and 3 staff members.

As a bipartisan political action committee HAMPAC provided campaign support funds to 47 legislative candidates during the 1976 Primary and General Election campaigns. In addition 1500 voter information pamphlets were mailed out to physicians and HAMPAC members.

Three meetings were held by the directors of HAMPAC during 1976. A HAMPAC representative attended the national AMPAC meeting in Washington D.C. during April.

In view of the increased involvement of physicians in legislative matters during this past year HAMPAC activities showed a marked increase.

Recommendations

1. That all physicians and their spouses continue their active support of HAMPAC and AMPAC during 1977 in view of legislative reforms that will be required to amend certain provisions of Act 219 that are inimical to physicians.
2. That $500 be included in HMA's 1977 budget for HAMPAC educational and administrative expenses.

L.Q. PANG, M.D.

Resolution No. 3—Act 219

HOUSE ACTION: Not Adopted

Whereas, the medical profession in Hawaii, through duly appointed representatives, has participated in good faith in the initial drafting of a bill relating to medical professional liability problems; and

Whereas, the result of such cooperation with the legislative process has been the revision of this bill into Act 219, SLH 1976, discriminating against the members of this profession; and

Whereas, the resulting law, working from a basic unwarranted assumption, singles out the medical profession as bearing the guilt for ills which it nowhere clearly specifies but which it uses as justification for making the physicians of Hawaii, individually and collectively, more vulnerable to litigation and deprivation of licensure;

Whereas, those with a knowledge of medicine and medical practice, in contradistinction to those with a knowledge of the trial process, are to be a minority of one on an arbitration panel established under this law;

Whereas, this law, in addition to possessing features oppressive to the medical profession, aggravates those real problems for which it was initially proposed as a remedy, now therefore be it

Resolved, that the Hawaii Medical Association urge the repeal of Act 219, Session Laws of Hawaii 1976, and seek to achieve this repeal by various means; that it pursue a continuing effort to assist the self-regulation and self-discipline of medical practice, using the legislative process only where absolutely necessary; and that the means used shall give due regard to the civil liberties of those who honestly and reputably have dedicated their professional lives to the practice of medicine.

CLAUDE V. CAVER, M.D.

Resolution No. 5—Act 219 Amendments

HOUSE ACTION: Not Adopted

Whereas mandatory medical liability insurance, mandatory proof of financial responsibility, and a patients' compensation fund are onerous, discriminatory and probably unconstitutional,

Whereas, the preamble to Act 219 assumes that medical malpractice is a problem in Hawaii, not the cost and availability of medical liability insurance,

Whereas the preamble to Act 219 acknowledges no evidence at any hearing to confirm the stated medical malpractice problem,

Whereas the preamble to Act 219 admits to and addresses to no other causes of the problem of medical liability insurance such as the effect of no-fault auto insurance, changing doctor, patient and third party relationships, insurance company settlements based on economic priorities, attitudes of judges and jurors in insurance reparations, the practice of defensive medicine, the breakdown of communication and personal relationships in today's society, the overselling of medical miracles and capabilities, inflation and greed,

Whereas the tort liability definitions fail to specifically reaffirm that the burden of proof rests with the plaintiff, or define "ipso res loquitur" in relation to the conciliation panel's ability to seek information,

Whereas the conciliation panel procedures do not include or consider structured awards, periodic payments, or coordination of collateral sources of benefits in making recommendations to the court,

Whereas the contingency fee schedule was actually raised,

Whereas the reporting by attorneys on outcome and fees was not included,

Whereas the statute of limitations in adults was not truly modified, and the statute of limitations in infants was not considered worthy of change, now therefore be it

Resolved that the Hawaii Medical Association recommend to the State Government of Hawaii: The repeal of sections of Act 219 dealing with mandatory medical liability insurance, mandatory proof of financial responsibility, and the patient's compensation fund,

The amendment of the preamble to Act 219 to acknowledge the problem of medical liability insurance, to acknowledge the lack of evidence of a problem in medical malpractice, and to acknowledge the existence of many other factors that contribute to the high cost of medical liability insurance,

The amendment of the tort liability definitions to reaffirm that the burden of proof rests on the plaintiff, and to eliminate "res ipso loquitur" as a legal tool.

The amendment of the conciliation panels' procedures to consider structured awards, periodic payments, and coordination of collateral sources of benefits in making recommendations to the court,

The amendment of the contingency fees section to reduce the contingency fees to a reasonable level, e.g. the "New Jersey rule":

50% on the first $1000 recovered
40% on the next $2000 recovered
33⅓% on the next $17,000 recovered
20% on the next $50,000 recovered
10% on any amount recovered over $100,000 whether by trial, pretrial or appeal,

The required reporting by attorneys on outcome and fees,

The amendment of the statute of limitations section so that the statute of limitations be two years from the date of alleged negligent act, or one year after the plaintiff discovers the injury, whichever occurs first, except that the statute of limitations should begin to run no later than age six on all infancy claims.

THEODORE TSEU, M.D.

Resolution No. 6—Amendments to Act 219.

HOUSE ACTION: With the permission of the introducer, Resolution 6 was withdrawn.

Peer Review and Finance Reference Committee

Commission on Peer Review

HOUSE ACTION: Adopted as follows:

The Committees under this Commission have met at least once during the past year. The Publications Committee and the Medical Education Committee, which were previously within this commission, have been re-assigned.

The **Maternal & Perinatal Mortality Study Committee** has continued its statewide review of all maternal & selected perinatal deaths. Under the excellent chairmanship of Dr. George Goto, and with the cooperation of Dr. Thomas Burch & Dr. James E. Drorbaugh of the State Department of Health, the Committee has investigated a total of 36 maternal & perinatal deaths. The subcommittee which screens perinatal cases to be presented to the full committee, reviewed a total of 53 cases. Both the subcommittee and the full committee are very active and the members deserve much credit for their time and efforts.

The **Peer Review Committee** met once to review a case referred to it by the Maui County Medical Society's Peer Review Committee. The case was subsequently referred to the Honolulu County Medical Society's Peer Review Committee, with the consent of all parties, because of the involvement of Honolulu physicians. The Committee has also acted in an advisory capacity through its chairman, Dr. C. M. Lum, to the Hawaii Medical Society's Peer Review Committee regarding a rather complex case.

The **Professional Liability Committee** has continued to review and make recommendations concerning the insurability of individual physicians. Dr. Bernard Fong has served as chairman of this very active and important committee, and the members are to be commended for their efforts in this very sensitive and critical area.

Recommendations

(1) That the HMA encourage more pediatricians and family medicine physicians who are involved in the care of mothers and infants to seek membership on and take an active part in the Maternal and Perinatal Mortality Study Committee.
(2) The Maternal and Perinatal Mortality Study committee should seek ways to involve all island physicians more effectively than in the past.

ANN B. CATTS, M.D.

Commission on Internal Affairs

HOUSE ACTION: Adopted

The Commission on Internal Affairs consists of the Convention Committee, the Bylaws and Parliamentary Committee, Auxiliary Advisory Committee, and the Publications Committee. The Bylaws and Auxiliary Committees did not meet during the year; the reports of the 1976 and 1977 Convention Committees and the Publications Committee are reprinted below:

1976 Convention Committee

The 1976 Convention Committee was selected early in December 1975 to meet and formulate plans for the 120th Annual HMA Convention. The theme, "Global Medicine and Diseases of Travel," was chosen and at that point committee members who would be helpful in developing this theme were selected.

The committee consisted of: Thomas J. Whelan, Chairman; R. Varian Sloan, Commissioner; Gary Glober, Doris Jasinski, Ivar Larsen, John F. McDermott, Jr., Wasim Siddiqui, Frank Tabrah, Herbert Uemura and Mrs. A. Clyde Rossbert, President of the HMA Auxiliary.

The committee met several times between January 5, 1976 and August 27, 1976 and selected its guest faculty and its program. Since the theme emphasized certain international aspects of disease, guest faculty from England, Hong Kong, and Okinawa were invited in order to bring first-hand knowledge of their special interests and the diseases of importance in their countries.

For the first time, HMA initiated postgraduate courses and four courses were offered: (1) Immunology, A New Frontier; (2) Parasitic Diseases; (3) Stresses of and Coping with Travel; and (4) Pulmonary Function: Evaluation and Management of Insufficiency. Panels and plenary sessions were designed to round out the program, adding strictly clinical presentations to balance the theme-oriented international subjects. All scientific sessions were held between 7:30 a.m. and 1:00 p.m. each day, Monday through Thursday, October 25 through October 28.

The guest faculty consisted of: Fritz Bach, Ph. D., Madison, Wisconsin; William G. Baldwin, M.D., Wenatchee, Washington; Charles I. Barron, M.D., Burbank, California; Denis P. Burkitt, M.D., London, England; Kevin M. Cahill, M.D., New York City, New York; Frederick W. Cheney, Jr., M.D., Seattle, Washington; Allan Granoff, Ph.D., Memphis, Tennessee; Masao Maeshiro, M.D., Okinawa, Japan; Sheldon Margen, M.D., Berkeley, California; Guan Bee Ong, M.D., Hong Kong; Paul M. Stevens, M.D., Houston, Texas.

A welcoming luncheon was arranged by the Convention Committee for the officers of HMA and local and guest faculty. Sportsmen's Night Dinner took place at Mid-Pac Country Club on Tuesday night, October 29, 1976. The annual banquet was held at 6:30 p.m., Friday, October 29, 1976 at which time introduction of guests and presentation of awards took place as well as a program which included dancing to Dr. George Takushi's "The Torchers."

House of Delegates met on Wednesday afternoon, October 27 and on Friday morning October 29.

The HMA Auxiliary offered to participate as hostesses for the annual convention and staffed a hospitality booth. In this capacity, the Auxiliary made all those who attended the meetings feel at home.

The HMA staff, in particular, Mrs. Bess Chang, and the administrative staff of the Department of Surgery, University of Hawaii John A. Burns School of Medicine performed admirably the many details which were necessary to bring together successfully this internationally-flavored program.

THOMAS J. WHELAN, JR., M.D.

1977 Convention Committee

The 1977 Convention Committee has already had several meetings, and has coordinated with Mr. Gale Jewett, Director of the Department of Continuing Education Seminars of the American Medical Association, to put on a combined meeting with the AMA Council on Scientific Assembly in cooperation with the University of Hawaii School of Medicine. The date of the meeting is October 31-November 4, 1977, at the Sheraton Waikiki Hotel. Topics for the workshops have already been selected, and discussion is being held on speakers for the plenary sessions.

JOHN R. WATSON, M.D.

Publications Committee

The Publications Committee continues to oversee the publication of the monthly HAWAII MEDICAL JOURNAL and the biennial Roster.

The HMJ remains an in-home informative vehicle and a scientific journal. It is presently solvent. A recent reader questionnaire whose resultant information would be used to stimulate local advertisement is still being tabulated.

The Roster, with Council approval, will begin annual publication in late 1977. This will permit earlier inclusion of new members and correction of printing errors.

Recommendations:

(1) Continued monthly publication of the HAWAII MEDICAL JOURNAL
(2) That HARRY L. Arnold, Jr., M.D. remain as Editor of the HAWAII MEDICAL JOURNAL for 1977.
(3) That the subscription rate for the HAWAII MEDICAL JOURNAL be increased to $10.00 per year (presently $8.00).
(4) that the HMA Roster by published annually.
(5) That a budget of $3,500 by designated for the 1977 Roster publication.

WILLIAM F. MOORE, JR., M.D.
R. VARIAN SLOAN, M.D.
Commissioner

Continuing Medical Education Committee

HOUSE ACTION: Adopted as follows:

The Continuing Medical Education Committee (CME) was active during the year and met on nine occasions. It was noted that the House of Delegates, at the 1975 Annual Meeting, designated the CME Commission as a separate commission under the HMA with the CME Committee as one of the committees.

The CME Committee this past year formally accredited a total of eight hospitals, one voluntary health agency, and one specialty society, and surveyed or resurveyed seven organizations. The committee also reviewed progress reports from four institutions. The survey teams were appointed by the CME Commission. Accreditation fees remained at $200 for institutions and others but were reduced to $100 for specialty societies.

The CME Committee was involved in the following activities during the year:

(1) Reviewed and asked that the calendar of events and CME column in the Hawaii Medical Journal be kept up to date.
(2) Reviewed material regarding CME requirements of other states.
(3) Developed, prepared, and mailed to the HMA membership a questionnaire regarding the members' attitudes to CME.
(4) Evaluated and determined that the HMA Annual Meeting Scientific sessions, developed by the HMA Convention Committee, should retain the planning function for such sessions, that the CME Committee should be in an accrediting function only, and that the CME Committee should have direct liaison with the Convention Committee.
(5) Discussed methods for the evaluation of CME performance.
(6) Reviewed and discussed the requirements for the AMA Physician's Recognition Award (PRA) and the pam-

phlet, "Essentials of Approved Programs in CME."

(7) Reviewed a request by the AMA Scientific Assembly to possibly hold an AMA Regional CME meeting in Hawaii sometime in the future and recommended that the HMA Council pursue this request with the AMA. At this time, the AMA plans to sponsor a regional CME meeting in conjunction with the HMA Annual Meeting of 1977 at the Sheraton-Waikiki.

(8) Discussed the various mechanisms for recordkeeping of CME activities for physicians in Hawaii and probable costs and determined that it is critical to have some form of recordkeeping. It decided to assist the State Board of Medical Examiners in establishing this recordkeeping mechanism for physicians' credit hours if they desired assistance.

The 1975 HMA House of Delegates adopted the requirement of evidence of CME by our physicians as a condition of membership. Our State Legislature has since passed amendments to our Medical Practice Act which does require mandatory evidence of CME for relicensure. The CME Committee of the HMA has been charged with the responsibility of evaluating the methods of CME which might be adopted by the HMA and by the State Board of Medical Examiners in implementing the new amendments to the Medical Practice Act. Adherence to the requirements of the AMA-PRA is based on a three-year period while our licensing time frame is a two-year period. The concern was over the flexibility of the AMA-PRA program; however, it does offer an existing and nationally-recognized CME program. The CME Committee did agree that the HMA should require the equivalent of the AMA-PRA program and that the HMA should issue its own CME certificates based on a shorter time period. The CME Committee agreed that the HMA CME award should require at least 50 credits earned per year of which at least 20 must be in Category I. The CME Committee also agreed that, for the HMA CME award, HMA should consider allowing 20 hours of credit under any subcategory of Category V.

Recommendations:

(1) That the HMA House of Delegates adopt the position that the mandatory CME requirements for HMA membership be based on the AMA's Physician's Recognition Award on a three-year basis.

(2) That the HMA recommend to the Board of Medical Examiners the adoption of the AMA-PRA award, or other specialty society award which is equivalent to the AMA-PRA award, as suitable evidence of continuing medical education.

(3) That the CME Committee make a recommendation to the 1977 House of Delegates regarding a method of recordkeeping for physician credit hours in CME activities to help the physician in meeting his requirements.

(4) That the HMA House of Delegates consider the adoption of a budget of $12,000 for the CME Committee for 1977.

(5) That the CME Committee reevaluate the mandatory CME Requirements on a yearly basis and report on a yearly basis for the next five years to the House of Delegates as to the type of CME Requirements judged best suitable for our membership.

WINFRED Y. LEE, M.D.

Continuing Medical Education Commission

HOUSE ACTION: Report received without adoption of recommendations.

The activities and scope of the continuing medical education commission is summarized in the report of the continuing medical education committee.

One of the major concerns and objectives of the CME commission in the last year has been to agree on the mandatory requirement of CME activities as a fulfillment of HMA membership. Although it is strongly felt that there is at the present time no definitive CME requirements that has been proven to be effective of a measure of physician competence, the CME committee felt that the existing AMA physician recognition award adopted by so many states of our nation probably is the best method of CME requirement that can be recommended in 1976. Accordingly, it has made its recommendation that the AMA award based on a three year basis or an HMA award based on the same HMA requirement but on a one year basis be the method of fulfilling CME requirements.

In view of the slight uncertainty as to what best fulfills CME requirements, that can be asked of our own membership, I recommend the following alternative to recommendation one of the CME committee:

1. That the HMA House of Delegates will adopt the position that the mandatory CME requirements for HMA membership be based on the AMA-PRA on a three year basis or a HMA CME award based on the fulfillment of 50 CME hours in any category that is acceptable in the AMA-PRA requirements on a one year basis.

The rationale of the above alternative is to encourage CME activities with a minimum requirement of 50 CME credit hours in whatever area a physician feels might be most beneficial to himself. One should then compare a physician who bases his CME requirements in this manner as to a physician who utilizes the AMA-PRA award which differs in that 20 credit hours of category I must be fulfilled.

It is difficult for an organization to recommend any form of definitive requirement when it still remains untested as to its effectiveness. It is for this reason that the following second recommendation is made:

2. That the CME committee reevaluate the mandatory CME requirements on a yearly basis and report on a yearly basis for the next five years to the House of Delegates as to the type of CME requirements judged best suitable for our membership.

WINFRED Y. LEE, M.D.

Hawaii Medical Journal

HOUSE ACTION: Adopted as follows:

The *Journal* has been published monthly during the past 12 months. The average size of each issue has been 36 pages (not counting tip-in advertisements). Each issue, on the average, has contained 12 pages of advertisements (including tip-ins), and the pages of articles have ranged from 3 to 7½, with the mean, the median, and the mode all being just over 5 pages. Editorials (all written by Fred Reppun) averaged 1 page; association news, 2 pages (5, if the transactions of the annual meeting are counted, since they ran 37 pages in the December issue). Continuing Medical Education got an average of 1½ pages, Henry Yokoyama's Notes & News 3, and the Hawaii Academy of Family Practice averaged ½ page.

Thus ⅓ of the magazine has been advertisements, and about 1/6 of it scientific articles; ⅓ of it has been Association affairs, as was mandated, in general terms, by the last House of Delegates.

A short new feature, and an excellent one, the Pathologist's Easy Chair, contributed by Francis Fukunaga, was reported read "always" by 59 of 352 responding to our recent readership poll, and "sometimes" by 111, a bit below average but not bad for a new feature. Henry Yokoyama's News & Notes, and Tom Thorson's HMA Reports, ran well above the average in both categories. Only 13 responders "never" read the scientific papers: a stalwart, honest candid—if ill-informed—minority; presumably the rate would have been higher among the nonresponders. There were 266 who read them "sometimes," and 58 who read them "always." Their quality was rated "excellent" by a kindly 44, "poor" by a stern 59, "fair" by 266.

Doris Jasinski continues to edit manuscripts, and Paul Steward "puts out the book" singlehanded in workmanlike fashion. We regret to report that we have not heard from Bob Moser or Wini Lee all year, and it seems probable that they are expending their efforts in other directions and should be relieved of their responsibilities here. Fred Reppun should be

promoted to Associate Editor in recognition of his major contribution to the *Journal's* duty to express editorial positions.

The Association is unlikely to suffer the embarrassment of some larger organizations, of having to run the risk of paying taxes on surplus income generated by a publication. If a modest subsidy is required by the *Journal* as it is now operated, however, we believe it would be a grave mistake to react by discontinuing its publication. It is clearly performing a useful service as a medium of information, at very moderate cost.

We do have a large problem in that many worthwhile articles have had to be rejected because we can only afford to publish one or two short ones in each issue, and we are running almost a year behind in spite of selecting only articles of Pacific Basin significance or immediate practice usefulness. We would like authorization to run a little bit further in the red, so that at least 2 articles, even if one is of moderate length, could be published in every issue.

With this one extra request, we recommend the continuing publication of the HAWAII MEDICAL JOURNAL on the same basis as during the past year.

HARRY L. ARNOLD, JR., M.D.

Building Management, Ad Hoc

HOUSE ACTION: Adopted with the recommendation that the committee become a standing committee.

The ad hoc committee on Building Management met several times this year with most of its efforts being concentrated on the physical move of the Hawaii Medical Association offices to 320 Ward Avenue and the leasing of the vacant spaces at the new building.

The move to 320 Ward was accomplished on August 21, 1976. Due to detailed preparations by all involved, the move went very smoothly with minimal disruption of services to our members. An open house is scheduled for October 28, 1976.

On May 28, 1976, the Council approved a budget of $50,000 to accomplish the move and prepare the offices for operations.

A one-year contract, with a 60-day cancellation clause, has been let to Hawaii Management Company to manage the building. The management company contract will be subject to periodic review to ensure that this service still can be best provided by Hawaii Management Company.

Approximately 13.9% of the space is currently vacant. It is anticipated that by the end of this year, all space will be occupied.

WILLIAM W.L. DANG, M.D.

Mabel L. Smyth Memorial Building

HOUSE ACTION: Filed

The following individuals represented the Hawaii Medical Association on the Mabel L. Smyth Memorial Building Board of Management for the year 1976.

Dr. Elmer C. Johnson
Dr. Grover Batten
Dr. Walter W.Y. Chang, *Alternate*

The following individuals represented the Hawaii Nurses' Association on the Mabel L. Smyth Memorial Building Board of Management for the year 1976.

Ms. Jeanie Barry
Ms. Sandra Chung
Ms. Althea Kamau, *Alternate*

The following individual represented Queen's Medical Center on the Mabel L. Smyth Memorial Building Board of Management for the year 1976.

Mr. Lester Gamble, *Alternate*

Building Improvements:

1. A panic fire door was installed to the back of Mabel Smyth Building replacing the old iron grill gate.

2. Alterations of a first floor ladies rest room was completed. This space is now used as an office for the Hawaii Nurses' Association.

3. First floor offices, rest rooms, hallway and the entire second floor have been painted this year.

4. In December 1975 the water line in front of the building broke. Extensive and costly plumbing work had to be done to rectify this.

5. In September the air conditioning motor in the attic of the building shorted out and caused an electrical fire. No damage was done to the building; however, a re-built air conditioning motor replaced the burned out motor.

Nurses & Physicians Exchange:

In September 1976 all Pageboy II radios were recalled and the newest model Motorola radios were issued to all Physicians subscribing to the PageBoy II radios.

Voice receiving radio subscriptions have increased from 188 to 256 over the past year.

Monthly radio messages have increased from 2,584 in September 1975 to 3,725 for the same month in 1976.

Activity Report:

A total of 385,546 calls were processed for the year. A monthly average of 32,121 calls. This amounts to an increase of 37,080 calls for the year or 3,090 calls per month.

Membership:

	1975	1976
Physicians	385	400
Registered Nurses	56	46
Licensed Practical Nurses	13	15

ELMER C. JOHNSON, M.D.

HMA Auxiliary, 1976-76

HOUSE ACTION: Adopted with the recommendation that Auxiliary dues be collected at the rate of $11 per member regardless of the month in which the member is accepted for HMA membership.

This year our auxiliary involvement has been at every level of its organization — national, state, and county. National activities included great involvement in the convention in Atlantic City because of Mrs. P. Howard Liljestrand's presidency of the AMAA. The Ad Hoc committee formed for this event did a splendid job. Emphasis on national continued with the AMA Clinical Meeting in Honolulu in November, attended by 12,000 doctors and families. Hawaiian hospitality was provided by auxiliary-planned hospitality and information centers, a historical fashion show, island food demonstrations, a house and garden tour, and hostesses for visitors from every state.

State projects have included a second edition of our cookbook, a joint activity of the auxiliary and members of WASAMA. Our Winter Workshop on the state level concerned malpractice bills currently before the legislature. Neighbor island auxiliaries held follow-up malpractice workshops, and members responded to two legislative alerts on malpractice.

Our members have been encouraged to participate in health-related activities other than those sponsored by the auxiliary. This was shown to be a factor in Kauai's auxiliary deciding to disband. Members on Kauai are extremely active in their community, and it seemed that there was no need for additional involvement as an auxiliary. After discussing the matter with our board and among themselves, they decided to remain an organized auxiliary. We are very happy with their decision.

AMA-ERF activities were varied, including a picnic, a musical extravaganza, a no-ball ball, bake sales, and cookbook sales. Medical students from Maui are recipients of their fund-raising efforts.

For reasons of economy, only two issues of our newsletter were published this year. Other types of printing must be explored because of continuing printing and postal rate increases.

Our International Health committee has sent 4,000 lbs. of medical supplies and pharmaceuticals to Africa, the Philippines, and Viet Nam. Maui County continues to support a

child in Hong Kong. Kauai County supports CARE.

WASAMA hosted a successful regional workshop. The local chapter has survived its struggle for existence, while national WASAMA's future is in question. The national auxiliary's proposal that WASAMA members become junior auxiliary members is being voted on now by all WASAMA chapters.

The auxiliary helped sponsor a benefit for the Hawaii Medical Library, "An Evening with Sammy Davis, Jr." This ambitious undertaking netted almost $11,000.

Projects undertaken and continued by counties have included distribution of new-mother informational packets in hospitals; recording of talking books for the Dept. of Education; assisting in Blood Bank programs; distributing medical translations to physicians, hospitals, and clinics; helping in Health Screenings for the Elderly; working in several ways for the Hilo Special Education Center; sponsoring Cardio-Pulmonary Resuscitation training sessions; presenting a GEMS babysitter course; and sponsoring a Guest Day program for community leaders.

To condense an auxiliary year to a page is impossible. We're thriving!

MRS JEROME L. TUCKER

Bureau of Research and Planning

HOUSE ACTION: Adopted with the recommendation that the Bureau gather information regarding the possibility of financial compensation for state association presidents.

The Bureau of Research and Planning was directed by the House of Delegates to formulate a policy handbook for HMA members. The committee has agreed on a listing of subjects to be included in the handbook and the staff has begun a search of the minutes of the House of Delegates meetings and Council meetings over the past five years. The committee will continue work on this project.

The Bureau of Research and Planning was also requested to review Resolution 20 of the 1975 House of Delegates which is reprinted below:

Resolution No. 20—The Office of Vice President

HOUSE ACTION: Referred to the Bureau of Research and Planning and Bylaws Committee for consideration of the maximum term of office of the HMA President and whether the office of President-Elect is to be maintained or abolished in favor of the office of Vice President. The committees were directed to report their recommendations to the Council and for final action by the 1976 House of Delegates.

WHEREAS the office of President of the Hawaii Medical Association has increased in complexity and responsibility during recent years and

WHEREAS the term of office of one year may inhibit the functioning of the president in an efficient manner because of the time needed to become familiar with total program involvement and

WHEREAS the present bylaws make it impossible for the president to serve more than one term, therefore be it

RESOLVED that the House of Delegates instruct the Bylaws Committee to prepare changes in the bylaws substituting the words "Vice President" for the words "President Elect" wherever they appear in the present bylaws, and make such other changes that may be indicated to make it possible for a president to be re-elected to office at the expiration of his term of office.

WINFRED Y. LEE, M.D.

The committee considered the interrelationship of the offices of president, president-elect, and vice president and how they have worked out on a practical basis in the past. Deliberating on the committee was the present president and two past presidents. Instances were cited in which the proposed changes were adopted in other localities and organizations.

It was suggested that the offices of president-elect or vice president be assigned certain specific duties which would prepare the officer for future responsibilities as president. It was felt that the office of president-elect puts more pressure on the incumbent to familiarize himself with the office of the president because his succession is a certain matter whereas the office of vice president is not by any means a pre-determined outcome. Cases have also occurred where a president-elect spent the year of office preparing for the presidency and then resigned without taking office.

In the matter of serving a second term in the presidency, it was noted that no matter how qualified a president might be there would still be no guarantee of re-election because we do not have a system of declared candidacy and nominations for offices are made by a nominating committee.

In summary, the Bureau of Research and Planning found advantages and disadvantages in making the proposed changes but felt that there was not sufficient reason at hand to warrant a change in the present system.

WILLIAM E. IACONETTI, M.D.

Community Research Bureau

HOUSE ACTION: Filed

The Community Research Bureau operates as a fiscal agent for funds designated for charitable, scientific, literary, or education purposes. Financial statements for the EMS grant which ended in September 1975 are on file in the HMA Office.

B. ALLEN RICHARDSON, M.D.

Long Range Planning Committee, Ad Hoc

HOUSE ACTION: Filed with the recommendation that the committee be discharged.

The Long Range Planning Committee held no meetings during 1976. The committee is pleased that one of the objectives of the committee has been accomplished — namely, the HMA ownership of its own building and the occupancy of the offices at 320 Ward Avenue.

The committee recommends that it be continued but that it meet only at the request of the President to address itself to the problems presented to it by the President.

GROVER H. BATTEN, M.D.

Resolution No. 2 — The Dang Plan

HOUSE ACTION: Adopted

Be it resolved, that loans to the Dang Plan from members having passed their 65th birthday, be on a voluntary basis.

WILLIAM W.L. DANG, M.D.

Resolution No. 4—Support of the Hawaii Medical Library, Inc.

HOUSE ACTION: Adopted

Whereas, the Hawaii Medical Library, Inc. represents a key resource for continuing medical education in this State, and

Whereas, rapid inflation and spiralling costs have resulted in increasing deficits, and

Whereas, concrete evidence of support from practicing physicians is a vital factor in securing other supplemental sources of funding, and

Whereas, the Hawaii Medical Association contribution to the library has remained at $100 for over 10 years, now therefore be it

Resolved, that the HMA House of Delegates authorize an increase in the contribution to the Hawaii Medical Library of $5,000 annually.

JOHN P. WATSON, M.D.
President, Board of Governors
Hawaii Medical Library






















ROCHE


AWAII MEDICAL
ASSOCIATION













Search Committee (Ad-hoc)

HOUSE ACTION: Adopted

The Search Committee was appointed to make recommendations to the Council in cooperation with the Honolulu County Society to select a successor to Mr. Thorson who had notified the presidents of the two organizations in May that he planned to retire effective December 1, 1976.

The committee met and recommended that Mr. Jon Won be selected for the position of Executive Director.

The council approved the selection of Mr. Won and the decision was concurred in by the Board of Governors of the HCMS so that Mr. Won will serve as the Executive Director of HMA and the Executive Secretary of HCMS.

We recommend that the committee be discharged.

WILLIAM W.L. DANG, M.D.

Treasurer

HOUSE ACTION: Adopted as follows:

The House of Delegates has before it the budget for 1977. They also have the financial reports for the year closing. It is notable that the proposed budget exceeds one-half million dollars for the first time in the history of HMA. This figure is exclusive of subordinate projects such as the EMS program and the Tumor Registry.

It does represent some changes in procedure and a new approach to the relationship between HMA and HCMS.

It is recommended that the Common Fund be eliminated and that the fiscal arrangement between HMA and HCMS be conducted on a contract basis. That the contract be predicated on previous experience based on the time studies conducted from time to time to evaluate the relative activities of the two organizations. The contract should be negotiated between the executive committees of both organizations.

The probable cost of legal action relative to the litigation over Act 219, the malpractice insurance act, is included in the budget (see Council Contingency). Recent favorable actions might mitigate this cost. It is advisable that we plan for the worst.

The request of the Finance Committee and the Council that the House of Delegates give advance approval of an assessment is simply an insurance that will be applied only if it becomes necessary. It is of great importance that the association be able to move quickly and with decision in this matter.

Recommendations:

(1) That the House of Delegates approve the negotiations for a contract relationship with Honolulu County Medical Society and the elimination of the common fund.
(2) That the House of Delegates authorize the Council to levy an assessment of not more than fifty dollars ($50.00) per member if the Council deems such an assessment necessary in 1977.
(3) That the House of Delegates adopt the budget as approved by the Council for 1977.
(4) That the HMA dues for 1977 remain at $215/member, recognizing that the House of Delegates in the past has recommended increments in line with the cost of living.

GROVER H. BATTEN, M.D.

Public Health Reference Committee

Commission on Public Health

HOUSE ACTION: Adopted with the following recommendations:

(1) That the Hawaii Medical Association support those activities of the Cancer Center dealing with basic research, epidemiology, cancer control and clinical investigation only.

(2) That the HMA representatives to the Executive Committee of the Cancer Center examine the areas of concern which have been identified and where there is no general agreement, bring this to the attention of the Executive Committee for resolution.

(3) That the Cancer Committee continue to work with the Executive Committee Administration of the Cancer Center to resolve these difficult problems.

The Commission on Public Health consists of the following committees: Cancer, Chronic Illness, Communicable Disease, Crippled Children, Sports Medicine, School Health, Substance Abuse, and Public Safety.

The committee on Public Safety did not meet during the year. Although the Crippled Children Committee did not meet, testimony was presented at Department of Health hearing on the level of fees for physicians' services under the Crippled Children Branch. The Substance Abuse Committee held one meeting to discuss legislative measures and no significant substance abuse legislation emerged from the past session.

The reports of the other committees in the commission are reprinted below:

Cancer

The Cancer Committee has conducted a preliminary survey of the activities of the Cancer Center of Hawaii, with the conclusions presented in the report printed below.

Since this report was prepared, on September 3, 1976, the following changes have taken place.

1. The Cancer Control Proposal has been modified at our request, as indicated by the letter of September 15, 1976 from the Director (Exhibit A).
2. The management of the data generated by the Cancer Control Proposal has been assumed by the Cancer Commission, as indicated by the statement from the Chairman (Exhibit B).
3. The report was reviewed by the Committee on September 22, 1976 with the conclusion that, while the areas of concern had been identified, there was not general agreement as to the best solution, particularly in regard to the clinical members of the Cancer Center staff.

Report of the Cancer Committee (September 3, 1976)

The Committee has conducted a preliminary survey of the activities of the Cancer Center, paying particular attention to those aspects having to do with patients: Clinical Sciences and Cancer Control.

The Clinical Sciences Program is predominantly concerned with national or local protocols involving radiation therapy, chemotherapy, immunotherapy, or combinations, with the goal of enrollment of all eligible patients. The program is conducted by part-time clinicians who derive salary and the use of facilities from the Cancer Center, and also engage in private practice.

The Cancer Control Proposal visualizes a comprehensive program involving patients with specific cancers, who will be followed from diagnosis to death. Included are screening, pathologic diagnosis, clinical diagnosis and management, guided by "state-of-the-art" review committee producing guidelines and suggestions for management. These committees also certify specialists, such as endoscopists, who are then qualified to accept referrals from the program. A key feature is a centralized and integrated information system, built upon the existing Hawaii Tumor Registry, and containing extensive information about each patient, accessible to authorized persons. Among the data available will be management of individual patients, suggested management guidelines, outcome, and statistics regarding number of encounters, type of encounter, work load, etc. Management is performed by a team composed of a variety of individuals, a minority of whom are physicians.

Hawaii Medical Association
1977 Budget—As Approved by the House of Delegates

	Actual Current Year to 8-31-76	Projected Current Year 12-31-76	1976 Budget	1977 Budget
INCOME:				
Membership Dues	180,683.00	184,000.00	184,000.00	185,000.00
Journal	41,989.00	57,000.00	53,000.00	59,000.00
Annual Meeting	—0—	21,200.00	25,000.00	67,000.00
Annual Roster	1,415.00	1,500.00	1,500.00	1,500.00
Indirect Cost Reimb. (EMS)	67,337.00	100,000.00	—0—	—0—
Indirect Cost Reimb. (TR)	24,469.00	36,000.00	—0—	—0—
Indirect Cost Reimb. (Others)	—0—	—0—	—0—	—0—
Interest Earned	—0—	7,500.00	3,500.00	3,500.00
Miscellaneous	95.00	100.00	300.00	100.00
Dues Collection Services	1,745.00	2,000.00	3,000.00	2,000.00
Pacific PSRO (Salary Reimb.)	19,833.00	51,500.00	22,000.00	111,000.00
Pacific PSRO (Services)	6,145.00	10,000.00	12,500.00	13,000.00
Fee Survey	380.00	500.00	1,500.00	5,000.00
Continuing Medical Education	650.00	800.00	1,600.00	1,000.00
Printing and Xeroxing	3,341.00	4,500.00	4,500.00	4,500.00
Contract Services (HCMS)	—0—	—0—	—0—	75,600.00
Other Reimbursed Revenues	5,540.00	5,540.00	—0—	—0—
Total Income	353,649.00	482,140.00	312,400.00	528,200.00
EXPENSES:				
Salaries	77,113.00	121,500.00	107,400.00	246,000.00
Actuary	1,778.00	3,000.00	—0—	3,000.00
Auditing	3,380.00	3,380.00	5,000.00	5,000.00
Auto Expenses	2,424.00	3,600.00	2,280.00	4,000.00
Computer Reports	218.00	300.00	300.00	300.00
Council Expenses	1,344.00	3,000.00	4,000.00	4,000.00
Donation	—0—	100.00	100.00	100.00
Dues & Subscriptions	470.00	700.00	950.00	750.00
HAMPAC	400.00	400.00	500.00	500.00
Insurance & Bond	1,860.00	3,000.00	2,900.00	3,000.00
Lease Rent—Office Equipment	2,958.00	4,100.00	2,700.00	4,200.00
Library Contribution	—0—	100.00	100.00	5,000.00
Legal & Professional	2,142.00	2,800.00	2,400.00	3,000.00
Meeting Expenses	5,828.00	9,800.00	4,300.00	10,000.00
Postage	2,743.00	5,100.00	5,400.00	5,200.00
President's Assistant	3,000.00	3,000.00	12,000.00	13,200.00
President's Contingency Fund	148.00	1,000.00	1,000.00	1,000.00
Rent	7,070.00	11,400.00	11,400.00	—0—
Repairs and Maintenance	882.00	1,300.00	1,400.00	1,200.00
Retirement Contribution	(3,815.00)	14,000.00	7,800.00	35,000.00
Stationery, Printing & Supplies	4,979.00	8,000.00	7,800.00	8,000.00
Taxes (FICA, U/C, FUTA)	7,731.00	11,000.00	8,200.00	12,500.00
Telephone	1,977.00	3,100.00	3,700.00	5,000.00
Travel	8,220.00	10,200.00	13,000.00	12,000.00
Auxiliary	6,888.00	7,000.00	9,300.00	11,000.00
Committee Expenses	7,012.00	8,000.00	10,000.00	17,450.00
Journal	27,990.00	50,000.00	54,000.00	52,000.00
Annual Meeting	37.00	22,600.00	21,000.00	24,000.00
Roster	—0—	—0—	—0—	3,500.00
Continuing Medical Education	989.00	1,000.00	12,000.00	12,000.00
Fee Survey	46.00	50.00	15,000.00	20,000.00
Depreciation	—0—	300.00	1,000.00	1,000.00
Special Authorized Expenses	5,390.00	6,000.00	10,000.00	10,000.00
Council Contingency	320.00	5,000.00	10,000.00	50,000.00
Miscellaneous	58.00	200.00	500.00	500.00
Total Expenses	181,580.00	324,030.00	347,430.00	583,400.00
NET INCREASE (DECREASE) IN FUND	172,069.00	158,110.00	(35,030.00)	(48,100.00)

Approved by the HMA Council, September 10, 1976

Hawaii Medical Association
Proposed Budget for 1977 Annual Meeting

	Actual Current Year to: 8-31-76	Projected to: 12-31-76	Budget 1976	Budget 1977
INCOME:				
Registration		2,700.00	6,000.00	50,000.00
Banquet		3,000.00	3,000.00	3,000.00
Breakfast, Lunch, Etc.		—0—	—0—	—0—
Sportsman's Night		1,000.00	1,000.00	2,000.00
Booth Rentals		11,000.00	11,000.00	12,000.00
Subsidies		2,500.00	4,000.00	—0—
Post Graduate Fees		1,000.00	—0—	—0—
Total Income		21,200.00	25,000.00	67,000.00
EXPENSES:				
Awards		300.00	100.00	500.00
Audio Visual		400.00	400.00	300.00
Auto Expense		—0—	50.00	—0—
Badges		—0—	150.00	—0—
Banquet		3,000.00	3,500.00	5,000.00
Breakfast, Lunches, Etc.		1,000.00	800.00	1,200.00
Booths (Exhibits)		2,600.00	2,600.00	3,000.00
Conference Materials		600.00	600.00	500.00
Hospitality		200.00	200.00	500.00
Hotel Rooms and Meals		600.00	600.00	600.00
Leis (Guests)		150.00	200.00	300.00
Music		350.00	350.00	500.00
Miscellaneous		150.00	200.00	300.00
Printing—Programs		1,500.00	1,500.00	1,500.00
Printing—Reports		300.00	300.00	500.00
Printing—Tickets		500.00	500.00	500.00
Photographs		75.00	75.00	100.00
Postage		—0—	—0—	—0—
Rental—Meeting Hall		3,000.00	2,000.00	1,000.00
Stationery and Supplies		—0—	—0—	350.00
Speakers		5,000.00	5,000.00	5,000.00
Sportsman Night Dinner		900.00	900.00	1,000.00
Sportsman Night—Liquor		500.00	500.00	750.00
Telephone		75.00	75.00	100.00
Security Services		400.00	400.00	500.00
Post Graduate Brochures		1,000.00	—0—	—0—
Total Expenses		22,600.00	21,000.00	24,000.00
NET INCREASE (DECREASE) FOR THE YEAR		(1,400.00)	4,000.00	43,000.00

NOTE: The 1977 annual meeting will be held in connection with an AMA Regional CME meeting. It is expected that 1,000 physicians will attend. Registration for the HMA meeting will be required ($50.00/each).

Hawaii Medical Association
Proposed Budget for 1977 Committee Expenses

	Actual Current Year to: 8-31-76	Projected to: 12-31-76	Budget 1976	Budget 1977
LEGISLATIVE:				
Legal Counsel	5,000.00	5,000.00	7,500.00	7,500.00
Dinner & Entertainment	—0—	—0—	—0—	—0—
Today's Health	304.00	304.00	300.00	300.00
Miscellaneous	328.50	329.00	400.00	400.00
Printing	1,362.40	1,362.00	—0—	1,500.00
Total	6,994.90	6,995.00	8,200.00	9,700.00
PUBLIC AFFAIRS:				
News Media Award	—0—	800.00	800.00	800.00
Science Fair	175.00	175.00	200.00	200.00
Physicians' Questionnaire	—0—	—0—	300.00	—0—
Tel-Med	42.00	50.00	500.00	6,000.00
Miscellaneous	—0—	50.00	—0—	50.00
Total	217.00	1,075.00	1,800.00	7,050.00
INTERPROFESSIONAL RELATIONS:				
Professional Liability				
Public Affairs				
Assn. of Profession				
Membership				
Total	—0—	—0—	—0—	—0—
OTHER COMMITTEES:				
Medical Education	(200.00)			(200.00)
TV-Radio				500.00
Total	(200.00)		—0—	700.00
TOTAL COMMITTEE EXPENSES:	7,011.90		10,000.00	17,450.00

Hawaii Medical Association
RVS Fee Schedule
Proposed Budget for 1977

	Actual Current Year 8-31-76	Projected Current Year 12-31-76	Budget 1976	Budget 1977
INCOME:				
Sale of RVS	380.00	600.00	1,500.00	5,000.00
EXPENSES:				
Spot Survey	—0—	—0—	—0—	—0—
Printing	—0—	—0—	15,000.00	20,000.00
Miscellaneous	46.00	100.00		
Total Expenses	46.00	100.00	15,000.00	20,000.00
NET INCREASE (DECREASE) IN FUND	334.00	500.00	13,500.00	15,000.00

Continuing Medical Education
Proposed Budget for 1977

INCOME:				
Subsidies from Hospital, Etc.	650.00	1,000.00	1,600.00	1,000.00
EXPENSES:				
Secretary	900.00	900.00	3,600.00	3,600.00
Travel & Consultants	—0—		8,000.00	8,000.00
Publications Calendar	—0—			
Miscellaneous	89.12	90.00	400.00	400.00
Total Expenses	989.12	990.00	12,000.00	12,000.00
NET INCREASE (DECREASE) IN FUND	(339.12)	10.00	10,400.00	11,000.00

Hawaii Medical Journal
Proposed Budget—1977

	Actual Current Year 8-31-76	Projected Current Year 12-31-76	Budget 1976	Budget 1977
INCOME:				
Journal Advertising—Local	96.25	14,000.00	17,000.00	14,000.00
Journal Advertising—National	24,500.00	35,000.00	28,000.00	35,000.00
Journal Sales & Subscription	7,864.00	8,000.00	8,000.00	10,000.00
Total Income	41,989.00	57,000.00	53,000.00	59,000.00
EXPENSES:				
Assistant Editor	5,208.00	8,000.00	8,000.00	9,000.00
Commission Paid	4,278.00	7,000.00	7,200.00	7,900.00
Copyrights	42.00	72.00	72.00	72.00
Discounts	1,164.00	2,000.00	4,800.00	2,000.00
Miscellaneous	15.00	28.00	100.00	50.00
Insurance	—0—	—0—	100.00	78.00
Postage	492.00	800.00	900.00	800.00
Printing	16,713.00	32,000.00	33,000.00	32,000.00
Stationery and Supplies	78.00	100.00	100.00	100.00
Salary				
Taxes				
Telephone				
Total Expenses	27,990.00	50,000.00	54,272.00	52,000.00
NET INCREASE (DECREASE) FOR THE YEAR	13,999.00	7,000.00	(1,272.00)	7,000.00
Less Unreceived Journal Adv.	5,473.00			
Net Increase (Cash Basis)	8,526.00			

Hawaii Medical Association
Proposed Budget for 1977 Annual Roster

	Actual Current Year 8-31-76	Projected Current Year 12-31-76	Budget 1976	Budget 1977
INCOME:				
Advertising				
Sale of Roster	625.00	1,000.00	1,500.00	1,500.00
Total Income	625.00	1,000.00	1,500.00	1,500.00
EXPENSE:				
Assistant Editor				
Commission				
Copyrights				
Discounts				
Printing				3,500.00
Postage				
Stationery and Supplies				
Total Expenses	—0—	—0—	—0—	
NET INCREASE (DECREASE) FOR THE YEAR	625.00	1,000.00	1,500.00	(2,000.00)

Hawaii Medical Association
Proposed 1977 Budget Building Fund

	Actual Current Year 8-31-76	Projected Current Year 12-31-76	Budget 1976	Budget 1977
INCOME:				
Rental	122,488.00	167,100.00		98,076.00
Parking	863.00	1,500.00		1,900.00
Reimbursement—Property Tax, Etc.	9,054.00	12,000.00		12,000.00
Interest	—0—	800.00		1,500.00
Total Income	132,405.00	181,400.00		113,476.00
SUBSIDY:				
Hawaii Medical Association				—0—
Hawaii Tumor Registry		6,600.00		17,280.00
Physicians' Exchange		1,550.00		9,336.00
Total Subsidy	—0—	8,150.00		26,616.00
Total Receipts	132,405.00	189,550.00		140,092.00
EXPENSES:				
General:				
Commission—Leasing	—0—	1,000.00		1,000.00
Depreciation	18,666.00	28,000.00		28,000.00
Interest—Mortgage	48,000.00	72,000.00		69,480.00
Lease Rent	21,920.00	32,880.00		32,880.00
General Excise Tax	5,052.00	7,250.00		4,540.00
Real Property Tax	6,124.00	12,240.00		12,500.00
Interest-Improvement Assessment	1,728.00	1,720.00		1,700.00
Common Area:				
Electricity	12,516.00	20,040.00		22,000.00
Insurance	1,700.00	3,400.00		3,400.00
Janitorial Services	3,780.00	7,560.00		8,000.00
Legal Fees	7,390.00	8,500.00		3,000.00
Maintenance—Air Conditioning	2,982.00	6,000.00		6,000.00
Maintenance—Building Repair	3,146.00	4,800.00		6,000.00
Maintenance—Landscaping	4,681.00	6,000.00		6,600.00
Management Fee	6,656.00	9,980.00		10,000.00
Professional Service	125.00	250.00		250.00
Refuse	632.00	600.00		600.00
Supplies	1,344.00	1,500.00		1,600.00
Water	582.00	1,100.00		1,200.00
Total Expenses	147,024.00	224,820.00		218,750.00
INCREASE (DECREASE) IN FUND	(14,619.00)	(35,270.00)		(78,658.00)
Add Non-Cash Expenses:				
Depreciation	18,666.00	28,000.00		28,000.00
Interest	48,000.00	72,000.00		69,480.00
Total Now Cash Expense	66,666.00	100,000.00		97,480.00
NET INCREASE—CASH FUND	52,047.00	64,730.00		18,822.00
Less Mortgage Obligation:				
Agreement of Sale (Princ. & Int.)	(66,666.00)	(100,000.00)		(100,000.00)
NET DECREASE IN FUND	(14,619.00)	(35,270.00)		(81,178.00)
Memo Only:				
HMA Share of Rental Subsidy (4,661 sq. ft. @ .90) = 4,195.00 × 12 =				*50,340

Hawaii Medical Association—The Capital Fund
Balance Sheet
September—1976

ASSETS

CASH FUND:			
Cash in Bank — Bank of Hawaii		5,072.60	
Cash in Savings Fund — Bank of Hawaii		50,000.00	55,072.60
LOANS RECEIVABLE FROM MEMBERS:			
Option #1:			
Total Commitments	48,000.00		
Less Payments	42,000.00	6,000.00	
Option #2:			
Total Commitments	156,000.00		
Less Payments	15,722.60	140,277.40	
Option #3:			
Total Commitments	61,000.00		
Less Payments	2,350.00	58,650.00	
Total Loans Receivable from Members' Commitments			204,927.40
Option Discounts			4,000.00
Total Assets			264,000.00

LIABILITIES AND FUND BALANCES

LIABILITIES:	
Loans Payable—Due Members	264,000.00
FUND BALANCES:	
Total Liabilities and Fund Balances	264,000.00

SCHEDULE OF MEMBERSHIP COMMITMENTS:

	Original	Payments	Balance
Option #1 (48 members @ 1,000.00)	48,000.00	42,000.00	6,000.00
Option #2 (156 members @ 1,000.00)	156,000.00	15,722.60	140,277.40
Option #3 (61 members @ 1,000.00)	61,000.00	2,350.00	58,650.00
Total (265 members)	265,000.00	60,072.60	204,927.40

Hawaii Medical Association
Community Research Bureau—Re: EMS
Statement of Receipts and Expenditures for the Period
July 1, 1976 to September 30, 1976

Receipts:	
Grant Received	150,458.99
Disbursements:	
Personnel Salaries	—0—
Fringe Benefits	373.95
Consultants Services	
Supplies & Postage	4,045.96
Seminar Date Preparation	
Rental	232.50
Publication	246.27
Travel—Domestic	892.44
All Others (Telephone, Adv., Xeroxing & Etc.)	2,948.16
Equipment	140,868.21
Total Disbursements	149,607.49
Indirect Cost @ 18.5%	—0—
Total Disbursements	149,607.49
Net Excess Receipts	851.50

The Committee felt that both aspects had developed in inappropriate directions. The efforts to enroll all patients with cancer in a vast, complex program covering all aspects of diagnosis and treatment, and centrally directed by the Cancer Center, can only result in deterioration of medical care. The Committee adheres to the view that a patient receives the best care from his personal physician, with appropriate consultation. This professional team is already working effectively; it seems foolhardy to supplant it by a group of amateurs. Those segments of the Cancer Control Program involving patient management should be deleted.

It was further noted that the Cancer Center does not have the staff or facilities to care for a significant number of patients. The experience of other centers has shown that such care is often below that of the community, as it relies upon house officers and para-medical personnel, rather than upon experienced physicians. The insistence upon participation in national or local protocols further compromises the quality of care, by shifting the emphasis toward compliance with the protocol, often to the patient's detriment. In a community where the average patient is in a private hospital under the care of his personal physician, the emphasis upon protocols seems misplaced. The Cancer Center can more readily make real contributions by conducting careful clinical studies in small numbers of patients. In the absence of a University Hospital or equivalent, large scale studies are impractical and should be discouraged.

The Committee felt that the members of the Clinical Sciences Section should be full-time with the Cancer Center and not part-time with the Cancer Center and part-time in private practice. The latter can assist, but not supplant, a core of full-time clinical investigators, whose entire commitment is to the Cancer Center. In briefing before the Committee it was stated that it was necessary to use the part-time format to provide adequate salaries because the University salary structure did not permit realistic salaries to be paid to clinical members. The Committee generally felt that the University salaries were adequate for full-time investigators and that efforts should be directed toward recruiting such individuals. Part-time appointments should further be discouraged because of the conflict of interest that could arise, and because of the temptation to use such an arrangement as a base upon which to build a private practice, with the ultimate goal of withdrawing from the Cancer Center.

The attempts to set standards of diagnosis and management, and the creation of memory banks of detailed individual information, are viewed as particularly dangerous and should not be permitted.

The Committee noted with dismay the marked polarization that has occurred in the community as a result of the activities of the Cancer Center. In seeking a cause, the Committee was not convinced it was intentional, and reluctantly concluded it was the result of ineptitude, either of administration or supervision. Both should be reviewed.

The information acquired suggests that the following measures be adopted:

1. The Hawaii Medical Association supports those activities of the Cancer Center dealing with basic research, epidemiology, cancer control and clinical investigation.

2. The Hawaii Medical Association does not support activities of the Cancer Center dealing with patient care.

3. The recruitment of full-time clinical investigators should be vigorously pursued; the utilization of part-time private practice to augment income should be discouraged.

4. The activities of the Cancer Center have been hampered by a reluctance to obtain appropriate consultation from the medical community. To help alleviate this problem, and at the request of the Director of the Cancer Center, the Cancer Committee of the Hawaii Medical Association is prepared to review any proposal, protocol or project submitted by the Cancer Center, in respect to scientific merit, suitability for this community and methods of implementation.

PAUL T. CONDIT, M.D.

Exhibit A

September 15, 1976

William W.L. Dang, M.D.
President
Hawaii Medical Association
320 Ward Avenue
Honolulu, Hawaii 96814

Dear Dr. Dang:

This letter is in further response to your letter of 3 September 1976 and today's telephone conversation with Dr. Paul Condit. I can appreciate your concern about removing statements in our proposal that can be misconstrued or are objectionable to some of your members.

In my conversation with Dr. Condit he suggested we make an addendum that would reflect the following points.

1) In the Data Information System section, Page 29, we delete No. 3 — "Current guidelines for case-management as developed by the "state-of-the-art review committee" and Rehabilitation/Continuing Care Teams" and also 4d) — "Number of ideal candidates versus number of patients actually treated by protocols with established risk factors. Standardized history taking will be tried in three hospitals for determining ideal candidates."

2) In all sections dealing with treatment intervention, we modify our statements or treatment guidelines to read as follows. Establish a "state-of-the-art review committee with Clinical Sciences Unit and community professional representation to review baseline data on treatment techniques prevalent in Hawaii. Review and critically evaluate all treatment methods presently known and make this information available for dissemination through the professional education program."

3) Remove any reference to a credential process for endoscopy since it is superfluous and already available through the hospital.

I have instructed our staff to make these changes and to make them known to our site visitors.

Dr. Condit also requested we clarify the administration of this program. The proposal calls for an Associate Director for Cancer Control who will have direct administrative responsibilities for the program including the hiring and supervision of personnel. He will report directly to me as Executive Director of the Center. Policies and modifications of the plan will be the responsibility of the Cancer Control Council. They will also approve key appointments presented by the Associate Director. Fiscal management of the program will be carried out by the Research Corporation.

I hope these changes and clarification meet with your approval.

Sincerely,

LAWRENCE H. PIETTE, PH.D.
Executive Director
Cancer Center of Hawaii

Exhibit B

September 29, 1976

MEMORANDUM

TO: William W.L. Dang, M.D., President

FROM: Grover Batten, M.D., Chairman, Cancer Commission

At its meeting of September 16, 1976, the Cancer Commission assumed the responsibility for the management of the data for the Community Based Comprehensive Cancer Program. The Cancer Commission also authorized the chairman of the commission to work with the officers of the HMA to decide the mechanisms regarding the details of the operation and to implement these through agreements with appropriate parties.

Chronic Illness

During the past year the Chronic Illness Committee met to discuss the revisions being proposed for the Mental Health Laws of Hawaii. Dr. George Schnack and Dr. Bernice Coleman, members of the DOH committee attempting to update the current law, provided the committee with a general outline of the areas deficient in the law at present and the proposed changes in these areas. The committee eventually recommended that HMA back the DOH in their revisions of the Mental Health Law and that HMA offer testimony in the legislature if they have alternatives to sections of the proposed law.

The committee also had an opportunity to submit physician's names to the Public Affairs Committee to serve on a "Medical Aspects of Aging" panel conducted during the Governor's Conference on Aging held June 7-12, 1976.

L. Clagett Beck, M.D.

Communicable Disease

The Communicable Disease Committee concerned itself with the possible outbreak of a "swine flu A/New Jersey" influenza epidemic. Dr. Robert Latta represented the committee at the National CDC briefings in Atlanta, Georgia in May of this year, while Dr. Roy Kuboyama attended the subsequent Regional meeting in San Francisco. Much of the discussion centered about the mass innoculations of the general population in Hawaii. Valuable opinions of prior programs of similar nature were provided by Dr. Samuel Allison, Dr. John Peyton, Dr. L.T. Chun and Dr. Donald Char while infectious disease expertise was provided by Dr. Francis Pien, Dr. Scott Halstead and Dr. Raul Rudoy.

As pointed out by Dr. Ronald Hattis, there were not further confirmed clinical outbreaks of "swine flu" due to influenza A/New Jersey since the original report from Fort Dix.

The committee then resolved the following:

(a) HMA commend the DOH for alerting the medical profession and lay public of a possible outbreak of a new strain of flu virus (A/New Jersey) and also be commended for their vigilent surveillance to detect swine flu;

(b) Recommend that the DOH stockpile the A/New Jersey vaccine for distribution and make it available through its usual clinics and that physicians be urged to administer the appropriate flu vaccine to the high risk group;

(c) Recommend that the DOH continue with a contingency plan for mass immunization and stand ready to execute it at a moment's notice when there is concrete evidence of clinical spread of swine influenza;

(d) Support the concept that the DOH continue its open relationship and communications with the HMA on the latest development of the swine flu program.

Franklin S.H. Young, M.D.

School Health

The School Health Committee met on four occasions to discuss the following problems:

(1) Department of Education Special Education—A letter was written to the Superintendent of the Department of Education from the committee about its concern to continue to have medical components in the evaluation and follow-up care of the child with learning problems.

(2) School Health Service Pilot Program—A letter was written to the Director of Health from the committee acknowledging the superb job done by retiring Dr. C. George Murdock as Chief of the School Health Branch. The committee also requested that the replacement of Dr. Murdock be one who has had experience in school health, training in pediatrics or a degree in public health. The new Chief of the School Health Branch is Dr. Jeremy Lam who is a pediatrician and has had training in public health.

(3) Hypertension screening for fourth graders in Hawaii public schools—The committee supported the proposal made by the National Heart and Lung Institute aimed at investigations of early precursers of hypertension.

(4) Streptoccal Survey—The committee approved a proposed streptoccal survey by the Hawaii Heart Association among school children in selected geographical areas with high incidence of rheumatic fever. It is hoped that by treating those with strep throat infections, the incidence of rheumatic fever and rheumatic heart disease will be decreased.

(5) Health Education in Public Schools—Representatives from the Department of Education and the University of Hawaii College of Education discussed the present programs of health education in the public schools and action which may be taken by the committee to make it more effective. The possibility of having health education courses as a required subject in the curriculum of future elementary school teachers is being pursued.

Recommendations:

(1) It is recommended that the House of Delegates approve the concept that the child's physician be included in the evaluation and follow-up care of the child with learning problems is necessary for the total care of the child.

(2) It is recommended that the School Health Committee continue to promote better school health education in public schools.

Roy F. Kuboyama, M.D.

Sports Medicine

The newly established committee on sports medicine met on four occasions during the past year. In addition to interested physicians, representatives from the Department of Education were also present at our meetings.

While the need for this committee seems obvious, and though the interests of the various groups in athletics seem to be present, this committee has had its problems getting off the ground. The traditional role of medicine has been one of responding to crisis problems which arise in the course of time. However, the role of our committee has had to be directed towards promoting safety, prevention of injuries, and preparation of personnel so that one is ready to respond when the need arises.

In light of this, the committee has attempted to focus on an educational program particularly aimed at school personnel. It has been our feeling that the school system, per se, needs people around the campus who can play an active and continuous role in this regard. Perhaps this concept is too idealistic at this time. We have considered and solicited help through the University of Hawaii, and the HMA Committee on CME but have yet to define a methodology which I feel can work.

Recommendations:

(1) That the HMA Committee on Sports Medicine continue to work closely in an effort to find a workable methodology to promote safety in school athletics.

(2) That the HMA advocate the teaching of CPR to those personnel who are actively involved in all organized athletics involving children and youth.

Michael M. Ohtsuru, M.D.
Roy F. Kuboyama, M.D.,
Commissioner

Report of the Cancer Center of Hawaii Representatives

HOUSE ACTION: Adopted

The Hawaii Medical Association has been represented on the Executive Board of the Cancer Center of Hawaii by Drs. Herbert Y.H. Chinn, Thomas K.L. Lau, Andrew Morgan, and Henry T. Oyama. Listed below is a synopsis of the activities of the Cancer Center as prepared by the executive director, Dr. Lawrence H. Piette.

"During the past year there have been further important developments in all components of the Cancer Center. The following is a brief report of new activities and expansion of programs undertaken during this period.

"Core grant funding for the Center began in 1974 as one of the specialized centers established throughout the country by the National Cancer Institute (NCI). During this second year in this status, the Center has moved ahead in many areas.

"In Basic Sciences, Dr. Roland W. Gillette has joined the staff as Director. He was Principal Scientist at the Meloy Laboratories in Virginia before coming to the Center. Under his direction, research is proceeding in immunology, molecular biology, clinical carcinogenesis and virology. Through renovation funds from NCI, a biohazard facility including a carcinogenesis lab and new animal facilities has been constructed. This facility will also be available to the state.

"In the clinical area, the momentum of the first years of activity under the direction of Dr. Noboru Oishi continues. The NCI contracts for the clinical education program and the radiation oncology program are now in the second year. The Hawaii Oncology Group, with Dr. Oishi as the P.I., is a probationary member of the Southwest Oncology Group and will apply for full membership in SWOG at the next quarterly meeting in October 1976. Dr. Kevin Loh was appointed Associate Director of Clinical Sciences on September 1, 1976. Dr. Loh is a hematologist and medical oncologist from M.D. Anderson. He will be working closely with others in the Clinical Sciences Unit to place patients onto cooperative studies and in other activities of the Unit.

"A number of new programs have been undertaken in the Epidemiology/Demography Unit including a study supported by the United States Navy on the health effects of asbestos among Pearl Harbor Naval Shipyard workers.

"The Center's control activities are now nearing the implementation phase. The Cervical Cancer Screening Program supported by NCI, which the Center has undertaken on subcontract from the Department of Health, has been approved at a level of $456,000 for the first year and a half of a three-year program. This program will screen 30,000 high risk women during the first period. The Community-based Cancer Control program plan has been submitted to NCI and, if approved, will begin in early 1977. This is a five-year program aimed at a coordinated approach to breast, cervix/uterus, colon/rectum and lung cancers. A large number of lay and professional people have been involved in the preparation of these programs throughout the state.

"In connection with the control programs, the Cancer Center has developed very close collaborative relationships with the American Cancer Society. The ACS has a large part to play in the Community Based Cancer Control Programs in the areas of professional and lay education and in volunteer contributions to many aspects of the program. Recently an agreement has been concluded which spells out the responsibilities of the ACS and the Cancer Center in this community with respect to all cancer activities.

"Funds for the Cancer Center building have been approved and an architect chosen. Completion of the building is expected in early 1978."

The HMA representatives on the Executive Board recommend that the Cancer Center of Hawaii be supported by the community but that delivery of medical services remain in the community, similar to the arrangements of the medical school at the present time. The representatives are also in concert with the measures adopted by the Cancer Committee of the HMA in their report to the House of Delegates.

HERBERT Y.H. CHINN, M.D.

Commission on Health Service and Care

HOUSE ACTION: Adopted with the request that the component committees of this commission resume their prior level of high activity.

The Commission on Health Services and Care includes three committees which were active during the year. These committees were quite active early in the year but with the malpractice problem and the move to the new building, were inactive later.

The Community Health Care Committee initially was chaired by Dr. George Mills but he resigned in April and was replaced by Dr. Claude Caver.

The major item accomplished was to develop jointly with the HCMS Utilization Review Committee criteria for Levels of Care in Skilled Nursing Homes. These were also approved by Maui County Medical Society, and the HMA Council and then forwarded to DSSH for their study.

Attempts to delineate criteria for Levels of Care at Intermediate Care Facilities were also made by this committee in cooperation with the HCMS UR Committee. Considerable difficulty has been encountered due to disagreements with DSSH who want the criteria very close to SNF criteria so they may downgrade SNF patients easily to ICF level where they can reimburse the facilities for patient care at a substantially lower rate. In the recent weeks, however, DSSH has suspended these negotiations as word is coming from Federal sources that maybe the reimbursement differential between SNF's and ICF's will be eliminated or at least substantially narrowed.

Other business accomplished by this committee was to refer a request for a certificate of medical need for a physician at Family Medicine of Hawaii, Inc. (a clinic at Kahuku, Oahu) to HCMS as this item referred only to that county.

The committee endorsed funding of Kokua Kalihi Valley Clinic by the Honolulu Chamber of Commerce but the request for this endorsement came so late that the C of C had already rejected the request by the time of the endorsement.

The Health Manpower Committee chaired by Dr. H.H. Chun had one meeting and discussed the Health Manpower Inventory file. This could be a prolonged project and was not started. Discussion on relationships to the nursing profession and other health professionals occurred. Over all interest in this committee was low this year.

The Disaster Committee under Dr. John Edwards did not meet but elements of it met with and supported the Honolulu Airport Disaster Exercise in 1976. A chain of communication for all those involved in the event of a disaster including physicians, police, ambulance personnel, etc. was solidified from this.

Recommendations:

1. **The Community Health Care Committee** should continue to monitor the problems of the long term facilities of each county and to evaluate other community health needs and programs such as Public Law 93-641.
2. **The Health Manpower Committee** should be appointed and the chairman, at least, monitor the health manpower needs of the State. Problems in this area could rise rapidly and a committee needs to be ready to evaluate them.
3. **The Disaster Committee** should continue and should be willing to assist the counties in any disaster exercise they plan.

DOUGLAS B. BELL II

Commission on Interprofessional and Public Affairs

HOUSE ACTION: Adopted with recommendations (1) That a letter of thanks be sent to the members of the Japanese Speakers Bureau, (2) That Tel-Med and other audio-visual activities be conducted under an expanded Public Affairs Committee and (3) That the Interprofessional Relations Committee's name be unchanged.

The TV-Radio people have breathed new vitality under the capable direction of Dr. Henry Yokoyama and have brought about numerous radio programs, are developing TV scripts which have been aired over Oceanic Cablevision and also are working with Punahou to develop commercials supporting the stop-smoking campaign and Tel-Med. They are working on a cadre of M.D. communications people and have developed excellent relationships with the community communications people including the educational as well as commercial stations.

The series "Medix" has begun and this is only through the efforts of this very viable committee which last year seemed morbund.

The Public Affairs Committee has met regularly and the year 1975-76 has been spent profitably we hope. The major efforts were expended on Tel-Med which is now a functioning stepchild of Dr. Winfred Lee who imported the concept to Hawaii.

It is being managed by consortium of two members of the HMA and HMSA and being financed largely by the HMSA with much "in kind" support from the HMA and a $6,000 grant from the Chamber of Commerce of Hawaii. We have developed and acquired approximately 250 tapes and are now having calls at the rate of one a minute through a 40-hour week.

We have considered several ethical questions over the year and will be asked to work on the telephone directory problem which was forwarded once before to the Council. Now with the multiple directories and the clear evidence of advertising we must once again attempt to spell out the limitations of this type of disclosure.

We were involved, pleasantly as usual, with the Science and Engineering Fair and hope to continue with this as long as the Fair remains a viable area to encourage medical involvement in young students.

We have continued to be involved with the Hawaii Newspaper Agency in multiple forums including Swine Flu, Death and Dying, Nutrition and Emergency Medicine with an average turnout of 600 people (400-1,200).

We elected, with the help of the entire membership, Dr. Ivar Larsen as Physician of the Year for 1975.

Our budget requests for the next year include the usual contributions to the Science and Engineering Fair, the awards for excellence in medical journalism and some financing for HMA's portion of the Tel-Med costs which involves the payment of the operator and housing of the unit. Administrative charges as well are supported by the Society.

We also recommend that consideration be given to splitting off Tel-Med and similar functions as separate committees.

The Japanese Speaker's Bureau has been continuing with weekly speakers in Japanese language thanks to a very few faithful men. The Japanese Speaker's Bureau people deserve a letter of thanks: Dr. Fukumura, Dr. Goshi, Dr. Kawasugi, Dr. Akagi, Dr. Yokoyama, Dr. Tajima, Dr. Natori, Dr. Ogawa and Dr. Tanaka.

The Interprofessional Relations Committee, now a joint committee of the HMA and the Hawaii Bar Association, which has been meeting for 18 years or more, seems now to be running out of steam. During the past twelve months, it met only four times, rather than almost monthly as in the past. It appears that the greatest contact between the two professions occurs in the area of personal injuries, with plaintiffs' and defendants' attorneys relating mostly to orthopedic and neurosurgical physicians. Topics associated with these practices arise most frequently, and since there is a relatively limited number of both attorneys and physicians in these fields, the committee is relatively stable, the old members do not have great stimulation, and the new members feel out of place. This year more physicians representing other fields of medicine were members, but did not bring new kinds of problems or maintain interest. However, despite the ill-will among physicians toward attorneys generally which was aggravated by the Medical Malpractice Act, there seems to be a friendlier atmosphere in these meetings with attorneys more willing to listen to physician's problems. Thus, one of the meetings was almost totally devoted to discussion of a complaint against an attorney by a physician, referred by the HCMS Peer Review Committee.

As is to be expected, during the year when malpractice was the major topic of concern to physicians, the committee had discussion on various aspects of the problem and the legislation as the bill went through. Another major topic was a re-revision to the inter-professional code with a recommendation that it be broadened so as to include insurance companies and their representatives. Relative to this there was special attention to suggestions that attorneys provide education for physicians as to meanings of terms they use in direct and cross examination with which physicians are inadequately familiar, and review of interminable treatment cases. The other subject given consideration was legal and medical definition of death, which was then selected as topic for the next symposium.

The Hospital Facilities Committee did not meet in 1976 although the chairman did present testimony in the Senate Health Committee hearing on Act 97 hospitals.

The Filipino Speaker's Bureau has had no activity since 1974, therefore it should be discontinued. The newest endeavor, Tel-Med, has proven to be quite time-consuming and seems worthy of a separate identity. I suggest it become a standing committee: "The Audio-Visual Education Committee," concerned with managing all audio-visual materials for public and professional education; for example, Tel-Med, Tel-Hospital, Public TV Education, CME tape and film library services, etc.

It is recommended that the Interprofessional Relations Committee be continued with perhaps a name change to "Medical-Legal Committee." The committee should continue with its projects in malpractice legislation, including revision of the present law, and revision of the inter-professional code, and also study the possibility of joint medical-legal educational courses that would qualify for CME Category I credit.

Budget Requests:

News Media Awards	$ 800.00
Science Fair	200.00
Tel-Med	6,000.00
TV-Radio	500.00
Miscellaneous	50.00
Total	7,550.00

ROWLIN LICHTER, M.D.

The Oahu Emergency Medical Services Program

HOUSE ACTION: Adopted

A System Overview

During the past three years, the City & County of Honolulu and the Hawaii Medical Association (HMA) have received funding from the Regional Medical Program Services and the Emergency Medical Services (EMS) Act to develop a basic life support system for the Island of Oahu. This system includes the advancement of the 15 mandatory components and the development of an EMS organizational unit.

The following paragraphs will briefly summarize the status of each of the fifteen mandatory components as they currently exist.

Manpower

To date, adequate numbers of manpower have been identified and involved in the system. In addition, the Oahu EMS Advisory Committee has been established to advise on the long-range goals of the Oahu EMS system.

Training

The HMA-EMS Program has developed specific training programs for all levels of personnel within the system (public safety personnel, Emergency Medical Technician-Ambulance (EMT-A), Mobile Intensive Care Technician (MICT)/paramedics, critical care nurses and Emergency Room physicians). There is a need to continue training of:

1. Key lay first responders; and
2. all groups necessary for an *A*dvanced *L*ife *S*upport System (ALS).

Communications

A bio-medical communications network is operational for the entire Island of Oahu. This system provided both telemetry and voice-related communications capabilities between all appropriate providers of emergency services throughout Oahu.

The ambulance central dispatch center has been modified to enable better communication with ambulance personnel in

the field. The dispatch system has been converted to UHF in order to provide greater compatibility with the existing bio-medical communication network which is also on UHF bands.

The emergency call number—911 has become an integral part of the emergency communications subsystem on Oahu.

The bio-medical communication network, central dispatch, and the universal call number —911 will facilitate and enhance the Advance Life support (ALS) system which is to be developed.

Transportation

The City & County of Honolulu ambulance service has in operation 15 new, modern, and well equipped ambulances which meet or exceed existing federal standards. The City & County of Honolulu and the HMA-EMS Program have worked with the U.S. Army to develop a MAST (*M*ilitary *A*ssistance to *S*afety and *T*raffic) Program for the Island of Oahu. Helicopters from the U.S. Army 68th Medical Detachment provide emergency air transport services for the Island of Oahu.

Since Hawaii is an Island State, there is a high incidence of water accidents. Sea rescues are coordinated with the U.S. Coast Guard's Joint Rescue Control Center and the City & County of Honolulu Department of Health, Department of Parks and Recreation, and Police and Fire Departments.

Ambulance response times within the urban areas of the Island of Oahu now range between 5 to 10 minutes.

Hospital Facilities

The HMA-EMS Program has categorized the ten acute care medical facilities throughout Oahu. The categorization results are becoming the standard for the triage of emergencies and the identification of areas needing improvement. Efforts have been made to ensure that there is at least one comprehensive facility on Oahu and that all hospitals designated as regional hospitals were upgraded to at least the Major category. All other acute medical facilities on Oahu have been upgraded to at least the level of Basic or Category D.

Critical Care Units

The critical care units on Oahu have been examined, and evaluated in conjunction with the categorization of the acute care medical facilities. Presently, there are sufficient numbers of critical care units on Oahu; however, there is a need to continue to identify population demands on these units as the system progresses to ALS.

Public Safety Agencies

Efforts have been preliminarily successful in involving all public safety agency personnel (fire, police, lifeguard) as Public Safety First Responders to care for and feed patients into the Basic Life Support (BLS) system and ALS pre-hospital units which are operational on the Island of Oahu.

Consumer Participation

A mechanism has been established for consumers to air their grievances and complaints regarding the EMS system. All complaints concerning the system are forwarded to the City & County of Honolulu Office of Information and Complaint for appropriate action.

Accessibility to Care

The City & County of Honolulu emergency ambulance services are provided free to the people of Oahu. All hospitals and skilled nursing facilities on Oahu provide emergency care without prior inquiry into patient's ability to pay. Thus, there has been full compliance with the intent of this component.

Transfer of Patients

A standard transfer agreement has been implemented throughout the Island. The form complies with Department of Health, Education and Welfare recommendations. A written inter-agency transfer agreement has been in existence throughout the State since 1966. The agreement addresses the basic conditions of patient transfer. In addition, the HMA has contacted the Chairman of the Hospital Medical Staff Committees and Administrators of all acute care medical facilities throughout the State to receive letters supporting the transfer of critical care patient groups when the need arises.

It is current policy within the City & County of Honolulu that patients in non-emergency state will be transferred using non-emergency type of transportation (private ambulance companies).

Standard Medical Record Keeping

A standard dispatch form, ambulance report form and Emergency Department form have been implemented throughout the Island. These instruments are used to provide the data base to evaluate the system and to provide management information.

Consumer Information and Education

Efforts have been made using all communications media to inform the consumer on the existence of the Oahu EMS system and services available. Providing data regarding the system's access and medical self-help have been major portions of the information and education campaign. For Fiscal Year 1977, the HMA-EMS Program has entered into a contract with Fawcett McDermott Cavanagh, Incorporated to further facilitate public information and education.

Evaluation

As the system progresses from BLS to ALS, periodic comprehensive review and evaluation of the extent and quality of the emergency health care services on Oahu will continue. The HMA-EMS Program is conducting a study to determine whether the system has had an effect on patient outcome. This portion of the evaluation is directed toward high risk cardiac and traumatic injury.

Disaster

Within the City & County of Honolulu and the State of Hawaii, disaster planning has been an integral part of all planning. The local disaster plans have been developed and are continually reviewed for revision. An inter-agency disaster exercise is conducted annually. The HMA-EMS Program and the City & County Department of Health are active participants in the exercise.

Mutual Aid

The HMA-EMS Program staff continues to work closely with the State Department of Health and all branches of the military services to develop procedures to make the Oahu EMS system's resources available to the Neighbor Island counties when the need arises. A portion of this objective was completed by the installation of a statewide bio-medical communications radio network. The Neighbor Island hospitals are able to transmit voice and physiologic data for consultative purposes 24-hours a day, 7 days a week.

Conclusion

Although some qualitative differences exist among the 15 components of the Oahu system, a BLS system has been 85% implemented. The City & County of Honolulu will complete the implementation of the BLS system during Fiscal Year 1977 with funds provided by a continuation grant from the Department of Health, Education and Welfare ($652,731.00). The activity necessary to accomplish completion of BLS is primarily the training of additional EMT-As. Concurrent with the completion of the BLS system, the City & County of Honolulu will work toward the development of an ALS system. This will be accomplished by improving the following components: Manpower, Critical Care Units, Facilities, Public Safety Agencies, Transfers, Standard Medical Record Keeping, Consumer Information and Education, Evaluation and Mutual Aid.

In order to assure that the populace of Hawaii are provided high quality emergency medical care, the Hawaii Medical Association is interested in exploring the feasibility of continuation of the EMS Program (particularly the Training component) on a Statewide basis, to become effective July 1, 1977.

Additional References

Chinn HYK: Emergency Medical Services—Hawaii. HAWAII MEDICAL JOURNAL 32:240, 1973.

Chinn HYK: Emergency Medical Services Program. HAWAII MEDICAL JOURNAL 33:477-479, 1974.

Sims JK, Akina S, Dods V, et al: The Emergency Medical Services Program of Hawaii. Part II. Emergency Medical

Technician (E.M.T.) Training of Hawaii's Ambulance and Rescue Personnel. Hawaii Medical Journal 35:227-232, 1976.
Dang W. Emergency Medical Services. Hawaii Medical Journal 34:439, 1975.

Calvin C.J. Sia, M.D.

Resolution No. 1—Emergency Medical Services Program

Whereas, the Hawaii Medical Association has sponsored the Emergency Medical Services Program (EMSP) for the past three years; and

Whereas, the EMSP developed in Hawaii has been recognized nationally as an outstanding program; and

Whereas, the need for training of new EMS personnel and for retraining of existing EMS personnel will continue to exist in our State; and

Whereas, the physicians of this state must continue to have strong input into the training and retraining programs of these types of EMS personnel; now therefore be it

Resolved, that the Hawaii Medical Association explore the feasibility of the HMA continuing the coordination, development, and administration of the comprehensive training and educational programs of the EMSP in the State of Hawaii.

Calvin C.J. Sia, M.D.

Cancer Commission

HOUSE ACTION: Adopted as follows:

The Hawaii Tumor Registry continues to grow and serve as the data base for reports, programs, and individual research. It has developed the capability of meeting all inquiries put before it. In addition, as a training facility, it is being used by the Kapiolani Community College for tumor registry training of some of its student medical records technicians.

There are approximately 25,000 patients in the registry and they represent in excess of 27,000 cancer primaries.

Of some concern has been a complex data system which has been proposed as part of the Community Based Comprehensive Cancer Program and is designed to be integrated with the Hawaii Tumor Registry. Concerns relate to the proposed broad use of confidential personal information by many individuals, and the line of management authority. Although some details are not resolved at this time, the consensus of the Cancer Commission is that policy regarding the project must be established by HMA and its Cancer Commission and that personnel should be under the HMA.

The Hawaii Tumor Registry moved to 320 Ward Avenue on October 1, with minimal operational disruption.

Grover H. Batten, M.D.

Ad Hoc Task Force on Diabetes

HOUSE ACTION: Adopted

The Ad Hoc Task Force on Diabetes was appointed by the HMA President with approval by the HMA Council in response to Public Law 93-354, passed by Congress in July, 1974, and known as the National Diabetes Mellitus Research and Education Act. This law directed the National Institutes of Health to establish a National Commission on Diabetes to formulate long-range plans to combat diabetes. The stated goals of the Act are:

1. to expand and coordinate national research on diabetes;
2. to advance the education of patients, health professionals and the general public on detection and control of diabetes;
3. to disseminate updated information about diabetes.

This Act provides for funds for which diabetes education and research programs can be established in an area based on:

a. the size of an area's population (population-based centers)
b. the environment of a community with regard to proven research capabilities (prevention and control centers).

It is anticipated that funding of programs under this Act will commence approximately in July 1977.

Dr. Terry Wong and I were asked to spearhead this ad hoc task force. This task force has gathered approximately 12 internist-endocrinologists from the medical community to assist in formulating developmental plans for a diabetes program in Hawaii under this Act. In its two initial meetings, the ad hoc task force determined:

1. that the State of Hawaii might not qualify for a population-based center but would not rule out any efforts to qualify under this section.
2. that a diabetes center of either population-based or prevention and control should be pursued for the State of Hawaii.
3. that the proposed project be entitled, the Hawaii Diabetes Research and Education Program.
4. that the primary goal of this proposed project be to improve the well-being of every diabetic in the State of Hawaii.
5. that the objectives of this proposed project be:
 a. to educate physicians, allied health personnel, diabetic patients and their families, and the general public regarding diabetes.
 b. to disseminate up-dated information on diabetes.
 c. to assist in the development of clinical and basic sciences research on diabetes commensurate with the physical and fiscal resources available in this State without direct involvement in patient care.
6. The organizational structure of this program be under the direction of the HMA by the establishment of a Diabetes Commission whose function will be in conducting the project and who will be responsible to the HMA Council.

Recommendations:

1. That the HMA House of Delegates adopt this report;
2. That the HMA House of Delegates endorse the actions taken thus far by the ad hoc task force on diabetes as noted in this report;
3. That the HMA House of Delegates instruct the ad hoc task force on diabetes to continue to pursue the feasibility of developing a diabetes project in Hawaii under this Act;
4. That the HMA House of Delegates authorize the HMA Council to determine if and when the HMA should make application for such a project.

Winfred Y. Lee, M.D.

AMA Delegate

HOUSE ACTION: Adopted with referrals of recommendations as follows: Recommendation No. 1 to the Bureau of Research and Planning; Recommendation No. 2 to the Commission on Health Service and Care; Recommendations 3 and 4 to the HMA Executive Committee. It was also voted to include $1,200 in the 1977 budget for travel and on-site visits as recommended in Recommendation No. 4.

The past year has been a year of actions and progress for the American Medical Association. The officers, trustees, delegates, and staff have worked hard to carry out the mandates of the membership.

Major areas of concentration of effort were medical liability insurance, national health legislation, medical education, continued development of sound fiscal base for the AMA, etc.

Membership is up and stable (7/31/76, 162,432 members) income exceeds expenditures, a realistic reserve is being reestablished (with the 1977 budget $11,565,000 is anticipated for reserve) and the missions of the AMA plan are being carried out.

The AMA leadership has maintained constant vigilance and unrelenting pressure to assure the membership that good laws pertinent to medical care are passed and unnecessary intervention in the practice of medicine by all levels of government is challenged.

Medical liability insurance readily available at a realistic premium continues to be the major concern of physicians in this country.

Your association has taken a positive step to assist in solving the problem by founding and funding the American Medical Assurance Company (AMACO) an AMA owned medical liability reinsurance company.

An increasing number of medical societies are developing their own captive liability insurance company. While attending a recent AMA sponsored medical liability insurance seminar for medical societies interested in establishing their own company, I made the following observations:

1. All parties were primarily interested in securing available coverage at affordable premiums.
2. Most plans have a "buy in" provision for interested physicians.
3. In already established captive liability programs, premiums have not generally gone down.
4. A clear firm peer review policy of physician members is essential.
5. Opportunity to purchase insurance by "high risk uninsurable" members of the sponsoring society must be provided.
6. A minimum of five years of investment and experience is necessary to determine the impact of the plan on the problem.

There were seven national Health Insurance Bills in the recently adjourned 94th Congress. No administration bill was submitted. Very little action was given to the seven bills. The major reasons for this lack of activity were the concern regarding cost of the proposed programs, wide disagreement on a funding base and plain politics.

The AMA sponsored HR6222 comprehensive Health Care Insurance Act of 1975 is being reviewed and readied for possible reintroduction in the 95th Congress. Free standing catastrophic insurance is becoming much more popular as the initial approach to National Health Insurance. The AMA worked hard and long to modify HR5546 the medical manpower bill passed by congress and waiting the president's signature.

Persistant effort by the AMA assisted in the removal of the undesirable feature of the bill. A few removed were as follows:

1. Federal government control of the numbers, type and distribution of residencies.
2. Compelling medical school graduates to pay back in money or by service in shortage areas for the capitation dollars alloted to the school from which the student graduated.
3. Establishment of federal standard for licensing and relicensing.

In September of 1976, there were 57,236 medical students in 116 medical schools in this country.

Included in the bill waiting for the president's signature are the following:

1. Capitation grants will be made to medical schools yearly starting February, 1978 at $2,000 increasing to $2,100 February, 1980.
2. By 1978 medical schools must have 35% of their residencies in family medicine, general internal medicine and general pediatrics. By 1980, this percent must be increased to 50%.
3. Alien foreign medical graduates will be required to return to their country of origin after their training is completed.

The AMA leadership, the House of Delegates and its committees, continue to work actively on many issues on a broad front. I will very briefly mention some of these areas.

1. Objected to HR9019, amendments to the Health Maintenance Organization Act, passed by the 94th Congress and waiting for the president's signature. The basis for objection was that the amendments reduce the patient's benefits package and that this legislation supports only one type of health care delivery system.
2. Fraud—Dr. James Sammons, Executive Vice President of AMA told HEW that the AMA is pledged to support "anytime it is needed anywhere it is needed" to "take all corrective actions that are appropriate for a professional organization to take" in instances of medicaid fraud. It is estimated by HEW that of the 15 billion dollars spent on medicaid 5-10% is attributable to fraud and abuse.
3. Confidentiality of medical records continues to be a major concern of practicing physicians. The AMA has provided state medical societies model state legislation for confidentiality. The House of Delegates reaffirms that authorization for release of information contain only that material necessary and required by the third party.
4. The AMA has objected to the National Health Planning and Development Act PL93-641 and has joined several state medical societies in a suit against the government.
5. Due process for medico-administration and medical training program facility was an issue discussed at the last House of Delegates meeting in June of 1976. State medical societies are encouraged to review this procedure in their state.

Also at this meeting the House unanimously supported the HMA invitation that Hawaii be considered for an annual convention or Interim meeting of the AMA House of Delegates after 1980.

Recommendation

1. A plan of goals and objectives be developed by HMA to fulfill the missions of this society for the next 5-10 years.
2. The HMA gather information regarding HMSA's community Health Plan (HMO). What is the distribution throughout the State? What method is utilized for physician reimbursement for service?
3. HMA provide for its membership a quarterly status report of the activities under PL93-641. Of special importance is the involvement of practicing physicians.
4. HMA review the experience of medical societies who have initiated their own captive medical liability insurance program. The HMA budget for 1977 should contain money designated for travel and onsite visits.

GEORGE H. MILLS, M.D.

County Society Reports

HOUSE ACTION: Filed

Maui County Medical Society

The Maui County Medical Society met regularly every third Tuesday of the month during the year. Again the most discussed business topic was malpractice insurance, and Dr. Albert Chun-Hoon gave an excellent dissertation on the whole subject. Other interesting meetings were with the State President, Dr. William Dang and Dr. David Oblon on swine flu vaccine. There are now 74 doctors in the Maui County Medical Society and this includes 3 new doctors joining this year and also two doctors who resigned during the year. During the year the officers were:

President	Clifford F. Moran, M.D.
Vice President	Russell T. Stodd, M.D.
Delegates	Denis J. Fu, M.D.
	Andrew Don, M.D.
	Jose L. Romero, M.D.
Alternates	Marion L. Hanlon, M.D.
	Mahmood Mirzai, M.D.
	Alexander C. Peat, M.D.
Councillor	Sakae Uehara, M.D.

CLIFFORD F. MORAN, M.D.

Honolulu County Medical Society

The major activities of Honolulu County Medical Society for the past year were related to the newly enacted Medical Practice Act. The February membership meeting was a briefing session by the HMA members of the Governors Committee to formulate such a bill, Doctors Alan Pavel and Albert Chun-Hoon and Mr. Tom Thorson, before the bill was introduced into the legislative session. They asked for the mem-

berships' help in lobbying to obtain the provisions that would be fair for physicians.

The March meeting was the annual visitation by the HMA President, Dr. William Dang, who described and showed slides of the new HMA Building at 320 Ward Avenue. Most agreed that it was a handsome building, fitting for a medical organization. Also, on the program was Mr. George Comomikes of Comomikes and Associates, a national medical practice management consultant firm, who gave some good pointers on medical business.

In May another membership meeting was devoted to the now passed Medical Practice Act with Dr. Chun-Hoon and Mr. Thorson backed up by Senator Patricia Saiki speaking and clarifying the issues. Several items were debated and resistance to the compulsory insurance clause, which had been opposed vigorously by HMA members, began to surface.

The June meeting was called *Legislative Legerdemain* and featured Dr. George Goto, Dr. John Watson, Mr. Thorson and Mr. Jon Won discussing several issues including PSRO, more on the Medical Practice Act and National health legislation.

A special meeting in September featured Mr. John Waluski of Argonaut Insurance Company briefing the membership on how malpractice premiums are derived and giving the bad news of the 47% premium rise and Mr. Wayne Minami, Head of the Hawaii Department of Regulatory Agencies, describing many provisions of the new Medical Practice Act.

The October meeting then was a happy yet sad occasion honoring our retiring Executive Secretary, Tom Thorson. We all wish him well.

In August HCMS moved its offices and operations to the new 320 Ward Avenue building with HMA. All seem happy with the beautiful surroundings and the better parking situation.

In September a new fiscal arrangement with HMA involving contracting for needed secretarial help, space rental and various other necessary housekeeping items was proposed and agreed upon by the Board of Governors and the HMA council. Under this arrangement HCMS will pay HMA, as fiscal agent, a percent of the annual cost of these items and this percentage will be negotiated from the quarterly time studies done by the staff each year. This simpler method will eliminate the Common Fund and one set of bookkeeping yet will keep HCMS autonomy and show our responsibility in running the common HMA-HCMS operation.

In other business during the year HCMS developed the criteria for review of Skilled Nursing Home care. Criteria for Intermediate Care Facilities are still being developed. In February the Board of Governors withdrew their representative to the Waianae Coast Comprehensive Health Center as they felt they had little meaningful input into the operation. Also, arrangements were made to provide peer review by the HCMS Medical Practice Committee early in malpractice claims against physicians who are not members of HCMS. These physicians will be charged for this service, which is required by Argonaut for all their policy holders at such times.

Finally, with the retirement of Tom Thorson, HCMS Executive Secretary as well as HMA Executive Director, much effort was devoted to selecting his successor. All involved agreed that the common staff operation has been reasonably successful and should be continued for at least the foreseeable future. It was further agreed that a single staff leader was essential in such a setup. Thus, after due deliberation and after HMA's selection of him for Executive Director, Mr. Jon Won, Tom's able administrative assistant, was selected for the HCMS post. We are confident he will perform well in this difficult job in challenging time.

In summary, HCMS has weathered an eventful year no worse the wear but several problems remain for the years ahead. The malpractice insurance problem and the compulsory insurance issue will need united and vigorous effort by all HCMS and HMA physicians, to solve. Lobbying in the legislature is tedious, boring business but will be necessary for us all. It is certainly cheaper than the projected U.S. Supreme Court route.

Douglas B. Bell II, M.D.

Nominating

HOUSE ACTION: Adopted with the exception of Recommendation No. 3 which was not approved.

The Nominating Committee met twice to receive nominations for needed offices of the Association. The committee developed a lengthy list of candidates, but the nominees refused. The following slate of nominees was submitted to be elected by the House of Delegates:

President-elect Marion Hanlon
Secretary Douglas B. Bell, II
AMA Delegate #2 Herbert Y.H. Chinn
Alternate AMA Delegates William W.L. Dang
(2 to be elected) William E. Iaconetti
..... Winfred Y. Lee
Kauai Councillor Peter Kim
Honolulu Councillors John W. Edwards, Jr.
(4 to be elected) John Kim
..... Calvin C.M. Kam
..... Elmer Johnson
..... Rowlin Lichter
..... Arnold Siemsen

All nominees have been contacted and have agreed to serve if elected.

Recommendations:

(1) It is recommended that the second AMA delegate be elected for a two-year term and that two alternates be elected for a one-year term. In the event of a reduction of delegates from two to one, the second delegate shall revert to alternate delegate and the two elected alternate delegates be declared out of office. The person who receives the highest number of votes will become the first alternate delegate.

(2) It is recommended that all past presidents of the HMA be exofficio nonvoting members of the Council and urged to attend all Council meetings.

(3) The Committee strongly recommends that Resolution 20, 1975 House of Delegates, be accepted (see also, report of the Bureau of Research and Planning for copy of resolution 20). In the event that Resolution 20 is accepted by the House of Delegates, then the nominees for president-elect become nominees for vice president.

The committee was unanimous that these changes be instituted.

Andrew L. Morgan, M.D.

Election

HOUSE ACTION: The report of the Nominating Committee was presented and the President called for nominations from the floor. There were no further nominations. Ballots were distributed and tellers were appointed. The following were elected:

President-Elect Marion Hanlon
Secretary Douglas B. Bell II
AMA Delegate No. 2 Herbert Y.H. Chinn
Alternate Delegates William W.L. Dang
..... William E. Iaconetti
Kauai Councillor Peter Kim
Honolulu Councillors John W. Edwards, Jr.
..... Calvin C.M. Kam
..... Rowlin Lichter
..... Arnold Siemsen

The Nominating Committee was elected as follows: Ralph Beddow, William W.L. Dang, Winfred Y. Lee, Andrew L. Morgan, R. Varian Sloan (Honolulu); Kenneth Hughes (Hawaii); Thatcher Magoun (Kauai); William E. Iaconetti (Maui).

New Business

HOUSE ACTION: The House of Delegates voted to commend Dr. William Dang and give him a standing ovation for his outstanding leadership as HMA President during the past year which included the purchase of a handsome new home for the Association.

Dr. Leonard Howard asked the delegates to indicate whether there was interest in inviting AMPAC to sponsor a workshop in Hawaii. The delegates agreed an invitation should be sent to AMPAC.

The meeting adjourned at 2:30 p.m.

R. Varian Sloan, M.D.

Awards

Medical Journalism

Pat Hunter—Honolulu Advertiser
Janice Wolf—Honolulu Star Bulletin

A.H. Robins Award

Livingston M.F. Wong

Sportsmen's Awards

Tennis:
Leabert Fernandez and Yutaka Yoshida—Doubles champions
Gene Doo—Singles champion

Ping Pong:
Philip McNamee and John Spangler

Fishing:
John Peyton

Golf:
President's Trophy—Herbert S. Takaki
Robert M. Miyamoto Perpetual Trophy—Herbert S. Takaki
John M. Felix Perpetual Trophy—Michael Okihiro
George H. Mills Perpetual Trophy for Pharmaceutical Representatives—Gene Machida
H. Tom Thorson County Society Trophy: Chew Mung Lum and Catalino Cachero (Honolulu Co.)

members of the American Academy following our 28th Annual Scientific Meeting in Boston.

Dr. Stuart Carne, Honorary Treasurer, RAGP, moderated the session at famous Grosvenor House. He is also the new president of WONCA (World Organization of National Colleges and Academies of GP's/FP's). The two solid mornings on the British National Health Service taught us much.

"Public Health" began in England 120 years ago with the establishment of a Central Health Department, according to speaker Sir George Godber, former Chief Medical Officer of the Department. Later, an Act of Parliament directed the government to become active in medical research, and in 1920 a major breakthrough occurred with the organization of the Medical Research Council. Research nowadays in England is largely commissioned on the basis of need. Private medical research, on the contrary, is as nothing compared with its role in the U.S.A., and even the M.R.C. is a twentieth the scope of our National Institutes of Health, although its impact on the world is considerable. The English government also supports research by university hospitals, but the latter guard their autonomy jealously.

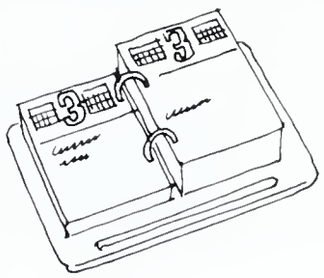
The British system of medical care is based upon a traditional relationship from time immemorial between the "specialist" and the "General Practitioner", in which the former accept patients only on referral from the latter. The other source of referral in modern England are the hospital emergency rooms. It was natural, therefore, for hospital medical staffs to become "closed", as the specialists worked mostly on in-patients and their follow-up. Patients paid their doctors in their offices ("Surgeries") privately, and they paid their hospital bills to include the services of the "consultants" for in-patient care. This sharp distinction in practice between those on the outside, the GP's, and those on the inside of hospital walls, the consultant/specialists, predated the enactment of the NHS in 1948, and was easily incorporated into it. The GP's then became salaried government physicians on a capitation basis.

Dr. Carne reported that 80% of the people are satisfied with the NHS and that it also goes well with the physicians of both types. This is not to say that the system is exportable. It is accepted in England because it encapsulates what was before. The role of the generalist has been preserved and strengthened by the NHS and most young graduates are now opting for general practice. One main reason is that the GP is rather an independent entrepreneur, even though paid by the government. The other big factor is that the open slots for young specialists in hospitals are few and far between with a resultant six to eight year waiting period during which the well-trained physician must assume a subservient role. The Reorganization Act of 1974 has helped a great deal in resolving many of the problems of the system.

With respect to hospital privileges, Carne said that the majority of British general practitioners are not interested in having them. He felt there was an acceptance of the principle of "delegation to the greater experience." We see this in our own country in terms of the evolution of specific centers and regionalization of care. Carne pointed out, however, that there was a difference in the United Kingdom as between urban and rural practice; in the latter instance, generalists often do have a larger measure of hospital privileges.

A small 2% of the population are *not* registered with the NHS. Physicians do accept private patients, but the latter may not have it both ways—the patient has to choose and register accordingly. The NHS is founded on the concept that the General Practitioner provides Primary Care. Unlike the system in the U.S.A., however, where there is a resurgence of the "Family Physician" as THE source of primary medical care, in the UK they take note of the fact that two out of three people are not in a family unit.

J.I.F.R.



Continuing Medical Education

CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, first Thursday, 12:45 p.m.

John A. Burns School of Medicine

1. University Grand Rounds in Psychiatry, Tuesdays, 10:00-11:30 a.m. at Queen's or St. Francis. (Contact

John F. McDermott, Jr., M.D. or Wen-Shing Tseng, M.D. for further info)
2. UH Medical Grand Rounds, Tuesday (1st & 3rd) 12:30-1:45 p.m., Mabel Smyth Bldg. 1¼ hr. credit. Contact: Irwin J. Schatz, M.D. Ph. 521-5064.

Kaiser Hospital
(Contact CME Dept. for further information)

Kauikeolani Children's Hospital
1. Weekly Grand Rounds
2. Weekly Monday Noon Seminars
3. Visiting Professor Program

Kapiolani Maternity Hospital
1. Grand Rounds, Wednesdays, 7:30-8:30 a.m.
2. Resident Conference, Tuesdays (except 1st), 1:00 p.m.
3. Ob-Gyn Department Meeting, 1st Tuesday, 1:00 p.m.
4. UH Seminars, Wednesdays, 3:30 p.m.
5. Perinatal Conference, Thursdays, 3:30 p.m.
6. Tumor Board, 1st & 3rd Fridays, 1:00 p.m.
7. Oncology Conference, 4th Friday, 1:00 p.m.
8. Visiting Professor Program

Kuakini Hospital
(Contact CME Dept. for further information)

The Queen's Medical Center
1. Medical Grand Rounds, Every Friday, 8:00 a.m., Kam Auditorium
2. Surgical Conferences, 1st Tuesday, 4:30 p.m., Kam Auditorium
 Medical-Surgical Conferences, 2nd Tuesday, 4:30 p.m., Kam Auditorium
 Surgical CPC, 3rd Tuesday, 4:30 p.m., Kam Auditorium
 Basic Science Lectures, Every Wednesday 7:15 a.m., Surgical Conference Room
3. Ob/Gyn Conferences, 2nd and 4th Mondays, 12:30 p.m., Blood Bank Conference Room
4. Pathology Conferences, Every Wednesday, 7:30 a.m., Blood Bank Conference Room
5. Pediatric Grand Rounds, 2nd Wednesdays, 12:30 p.m., Harkness 128
6. Orthopedics Conferences, Every Friday (except the last), 7:30 a.m., Blood Bank Conference Room
7. Tumor Conferences, Last Tuesday, 7:30 a.m., Kam Auditorium
8. Urology Grand Rounds, as designated
9. Psychiatry CME Conference, as designated
10. Neurology/Neurosurgery Conference, as designated

Hickam Clinic
1. Clinical Correlation Conference, 1st Thursday, 11:00 a.m.
2. Didactic—our staff, 2nd Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, 3rd Thursday, 11:00 a.m.
4. Radiology Conference, 4th Thursday, 11:00 a.m. (Contact H.P. Stern, Capt, M.D., MC at 449-9742)

St. Francis Hospital
1. Medical Grand Rounds, Tuesday (4th & 5th) 12:30-1:30 p.m. Sull. IV Classroom
2. Surgical Grand Rounds, Fridays (except 4th) 7:30-8:30 a.m.
3. Tumor Conference, Mondays, 7:30-8:30 a.m.
4. Visiting Professor Program
5. EENT Teaching Rounds, Tuesday (1st) 7:00 a.m.
6. Psychiatry for the Non-Psychiatrist, Tuesdays (2nd) 12:00-1:00 p.m.
7. Surgical Mortality & Morbidity Conference, last Friday, 7:30-8:30 a.m.
8. Saturday Teaching Rounds, Saturdays (except 4th) 7:30-8:30 a.m.

Straub Clinic & Hospital
1. Medical Grand Rounds, first Thursday, 7:00 a.m.
2. Surgical Mortality & Morbidity, 4th Thursday, 7:00 a.m.
3. Quarterly Professional Staff Meetings, (Jan., Apr., Aug., Nov.), 4th Monday, 7:30 p.m.

Wahiawa General Hospital
1. Noon Seminars, 2nd Friday & 4th Tuesday

Wilcox Hospital (Lihue)
1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—2nd Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Hawaii Radiological Society meetings, 3rd Monday of each month, 7:30 p.m. at Straub Hospital. Contact Dr. Michael McCabe before each meeting to confirm attendance.

HMA Maternal and Perinatal Mortality Study Committee meetings, 1st Monday, 7:30 p.m. & 2nd Wednesday, 12:30 p.m. of each month in the 320 Ward Ave. Building. Contact HMA Office as dates are subject to change.

Monthly Film Showings (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817
At: Honolulu County Medical Society and Local Hospitals, Honolulu
Type: 1, 1 hr/day, 1 day/mo from 12 mos
Fee: None Methods: AV, O, Pan
Dates: All yr, 12 hrs instruction

Telephone Task Force—Hawaii (B) American Cancer Society, Hawaii Div., Inc., 200 N. Vineyard Blvd., Honolulu 96817
Type: 1, 1 hr/day, 1 day/mo for 8 mos
Fee: None Methods: AV, Clin C, O, Pan, R
Dates: Arranged; 8 hrs instruction

SPECIAL EVENTS

Jan. 11-13, 1977 (Course 1)	Basic & Advanced Cardiac Life Support Cert. Courses for Phys. Staffing Emergency Rooms" Am. Heart Assoc-HMA Emergency Med. Serv. Program & ACEP-Hawaii. St. Francis Hsp., Ward 2B-Ed. Auf. 2230 Liliha St. Hono. 3 days-22 hrs. Cat. 1 AMA; AAFP-24 hrs. & ACEP Cat. 1-22 hrs. Contact: J.K. Sims, M.D. HMA/EMS; 1301 Punchbowl-Hono. 538-9011 ext. 471.
Jan. 17-20, 1977	"Ischemic Heart Disease, Problems & Perspectives", Royal Lahaina Hotel, Maui, HI. Cat. 1—13 hrs. credit. Contact: Mr. Harold Brown, phone 373-3045.
Jan. 18-24, 1977	Hawaii Hsp. Medical Staff Conf. (B-350) Estes Park Inst., Box 400, Englewood, CO 80110. 6 days, Fee $175, 30 hrs. To be held at Kauai Surf Resort, Kalapaki Beach, Kauai.
Jan 23, 1977	Cancer in the Aged (B-100). Straub Clinic & Hsp. 888 So. King St., Hono, 96813. Co-Sponsor: American Geriatrics Society. 1 day-6 hrs. Fee $40.
Jan. 24-28, 1977	Advanced Techniques & Complications of Total Joint Replacement. Joint Implant Surg. & Research Foundation, 1300 N. Vermont Ave. S 601-Los Ang. 90027 for contact. Held: Kona Hilton, Kona. Fee $350.
Jan. 25-27, 1977	Hawaii Post-Conf. Workshops-Maui Surf Resort, Kaanapali Beach, Maui. Fee: $100. Contact: Estes Park Institute, Box 400, Englewood, CO 80110.
Jan. 27-March 31, 1977	"Interdisciplinary Health Team Development"—Manoa Campus, Schl. of Med. Thurs. 6-9 p.m. 8 sessions, 24 hrs. Cat. 1. Contact: John Watson, M.D. 948-8895 or Mrs. Bermosk 948-7053.
Jan. 31-Feb. 5, 1977	Prenatal Med.-Royal Lahaina Htl.-Maui. Contact: Univ. of Southern Cal. Sch. of Med, 2025 Zonal Ave. LA 90033.

Feb. 20-25, 1977 — "Advances in Patient Care" 5 day Conf. 24 hrs. Cat. I. Maui Surf Hotel, Kaanapali Beach. Write or call: 315 University Dist. Bldg. 1107 NE 45th St., Seattle, Wash. 98105-(206) 633-0505.

OUT OF STATE

For information on any out-of-state programs or courses, refer to August 11, 1976 Supplement to JAMA or call the HMA Office.





Angelita O. Catalan, M. D.

67-370 Hoana Street
Waialua, Hawaii 96791

INTERNAL MEDICINE



Alvin S. Fuse, M.D.

880 Kam Highway
Pearl City, Hawaii 96782

INTERNAL MEDICINE



George Heitzman

Box 2367
Kailua-Kona 96740

GENERAL PRACTICE



Kevin K. Loh, M.D.

Queen's Medical Center
1301 Punchbowl Street
Honolulu, Hawaii 96813

INTERNAL MEDICINE/HEMATOLOGY
MEDICINE ONCOLOGY



Jose M. Madamba, M.D.

1239 Wilder Avenue
Honolulu, Hawaii 96822

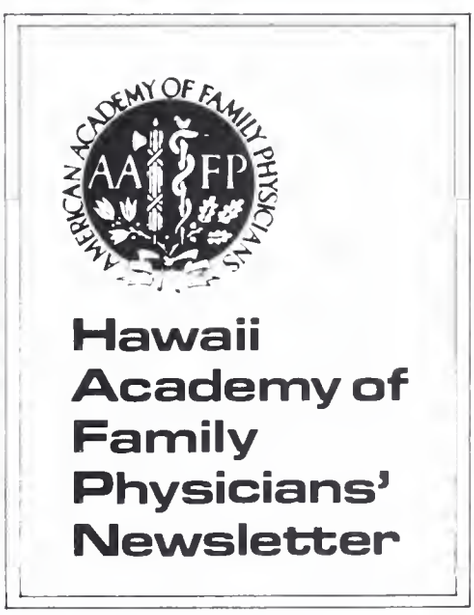
GENERAL SURGERY



Hugh H. West, M. D.

P. O. Box 1266
Kailua, Hawaii 96734

EMERGENCY MEDICINE



New Members—We have four new Student members aboard, all from UHSM '79: **Stephen Denzer, Helen Petrovitch, Bruce Hong,** and **Glen Sugiyama.** Welcome!

News of Members—Frank Tabrah and **Juan Tomas Van Putten** have become Active members. **Roscoe Pebley** has given up the practice of Medicine and has become Inactive. So has **Barton Eveleth,** long-time Kohala resident. His erstwhile partner **Michael Padwick** is seeking a replacement; Mike also is looking for a *locum tenens* for June, July and August 1977 for himself. **Vit Universal Patei** has gone into psychiatry and therefore ineligible for AAFP membership; he is being dropped from our rolls.

Pan Pacific Surgical—we understand, for the first time will have an AAFP member on its program committee for its Special "Seminar on Trauma" 3-8 April 1977.

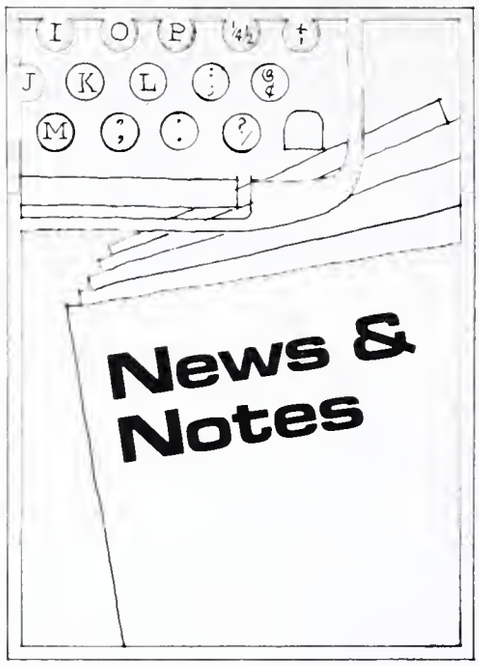
GAFP—The Georgia Academy has refunded $40 to the HAFP as a bonus for the registration of four of our members in their 1977 Family Medicine Refresher Correspondence Course 100.

Iowa—The Dept of FP, U of Iowa College of Medicine is looking for people to fill faculty openings. Anyone interested in freezing?

Boston—We have received certificates of registration at the 1976 Scientific Assembly 20-23 September for **Bob Bell, Homer Benson, Don Farrell, Felix Lafferty, Fred Reppun, Marc Schlachter.** The latter two also were accredited for the London meeting that followed. Total number of physicians registered at Boston was 3,663, up slightly from the 1975 Chicago meeting, but 1,315 down from the 1974 Los Angeles meeting.

H.A.F.P.—Our Annual Meeting and Election of Officers will take place on *15 January 1977* at The Willows. **Leslie Huffman Jr.**, President A.A.F.P. will be our guest and will install the new officers. At the Council meeting in November, it was decided that the annual meeting in 1978 will include a Scientific Seminar, and annually thereafter.

Dinner Meeting—on 20 November at the home of **Dr. & Mrs. Lincoln Luke** in Kailua had one of the all-time high attendance of over fifty. Perhaps it was the guest speaker and his flaming red hair and gift of gab. Perhaps it was the subjects, and Claude Caver handled both extremely well: "The Modern Treatment of Leprosy" and "The Roll of PPAH (Physicians' Protective Ass'n Hawaii) in Medical Liability."



HENRY N. YOKOYAMA, M.D.

Tom Thorson's Corner

A group of visiting protestant clergy and another group of local liquor dealers were meeting in adjacent banquet rooms in a Waikiki Hotel . . . The liquor dealers had ordered their favorite desert of watermelon spiked with Benedictine and brandy . . . But as often happens, the special desert was delivered by mistake to the clergy meeting . . . The frantic manager, on learning of the catastrophe, asked the head waiter if there had been any complaints from the clergy . . . The observant waiter replied, "No sir! They were too busy sneaking the seeds into their pockets . . ."

Al died and arrived at the Pearly Gates . . . St. Peter reviewed his record and observed, "You are a borderline case . . .

Your Patient is Our Concern

Artificial Limbs - Orthopedic Supports

Orthopedic and Custom Shoes

Home Care Invalid Equipment

Mastectomy Fitting Specialists

Certified Fitters

C. R. NEWTON CO., LTD.

1575 S. BERETANIA ST.

TELEPHONE 949-8389 or 949-6756 or 941-0433

and have the choice of either staying up here or going to Hell . . . Why don't you look around and make up your own mind." "Right neighborly of you St. Peter," said Al gratefully . . . Al toured Heaven with his angel guide and saw none of his old buddies . . . The angels simply played their harps and looked peaceful . . . Al was disappointed . . . His angel guide next took him down to Hell for a look see . . . There was his ole gang boozing it up and raising cain with lovely gals just like back on earth . . . "This is for me," decided Al . . . "Hell isn't all that bad . . ." "I'll take Hell," Al told his guide. And presto! He found himself mired up to his neck in sewage with the others and Satan was going around with a blow torch scorching the bobbing heads . . . "Hey! This isn't the Hell I just saw!" Al protested . . . "But then you were a tourist," came St. Peter's faint mocking reply from above . . .

Life in These Parts . . .

Therapeutic trial . . . When our son Roger bruised his leg during baseball practice, Pal Eldredge, Punahou varsity coach examined the injury and told him, "Tape and Asprin" (ie: trainer lingo for injury of no consequence). Pal says, Roger showed up next day with an asprin carefully taped over the leg bruise and informed him that it really hadn't helped much . . .

In early November, Hawaii ranked 2nd to Wyoming in the percentage of persons immunized against Swine Flu . . . Hawaii had 40% while Wyoming had 54% . . . This record, despite the efforts of Hanapepe's **Ron Hattis** who has been crusading against the government sponsored Swine Flu program. Ron, a former U.S. Public Health Officer, feels that the program is politically motivated and that the present strain is not the strain that caused the 1918-19 epidemic. Ron says ruefully, "There's nobody with the guts to change the program . . ."

We have the dubious honor of leading the nation in new TB and leprosy cases because of the influx of immigrants. . . UH pathologist **Olaf Skinsness** reports that the picture for leprosy is encouraging—the incidence in the Far East and the Pacific is dropping with improved diet and the use of sulfone drugs which means fewer immigrants with leprosy. Health Department's **Kirsten Vennesland** is less optimistic about tuberculosis because the State has neither the staff nor funds to put all tuberculin positive immigrants on medication . . .

Hawaii also leads in salmonella infections (8 times higher than the national average), which is another disease related to the high immigrant population . . .

A Willis Tsang in a letter to the Editor of Hawaii Times thanks dermatologist Cyrus Loo for curing with acupuncture his high blood pressure of 30 years requiring 6 pills a day . . . "From a BP of 180/110, my pressure is now 115/60 without pills . . . Visit Dr. Loo if you have a similar problem . . . You, too, can live a normal happy life again. Be free of pills and look forward to a healthier longer life."

Happy Sequel . . . In 1965 Malgorzata Domarowicz, a 17 year old girl from Poland came to Honolulu for a cervical spine tumor surgery by famed Honolulu neurosurgeon **Ralph Cloward** through his anterior approach. Today, 11 years later, she is well, a professor of mathematical cybernatics, married and expecting her first child. In true Aloha tradition, Queen's Hospital, Sheraton Hawaii, and Ralph refused to charge and the Honolulu Rotarians assumed the cost of airfare and other needs . . .

"Speaking of aging, **Harry Arnold** at the Straub Clinic says two things happen to you when you get older . . . 'One is you forget things and two . . . um . . . I can't remember the second.'" (Daacon—*Advertiser*)

The HMA and three physicians, **Claude Caver, Herman Kraener** and **Bernard Fogel** are suing the State over the constitutionality of the new medical malpractice insurance



BLEMISHES?

COVERMARK conceals all skin discolorations . . . birthmarks. brown & white patches, broken veins. tattoos. burns. scars. on any part of the body. COVERMARK is also unexcelled as an overall makeup . . . will not rub or flake off. Waterproof and Sunproof.

Lydia O'Leary
OF HAWAII
ALA MOANA CENTER—STREET LEVEL
PHONE 949-3288

BUREAU OF MEDICAL ECONOMICS
"PROFESSIONAL COLLECTION SERVICES FOR HAWAII'S MEDICAL COMMUNITY"

BETTER RESULTS IN COLLECTIONS OF YOUR DELINQUENT ACCOUNTS.

PHONE 536-9691

THE BUREAU OF MEDICAL ECONOMICS
A SUBSIDIARY OF HONOLULU COUNTY MEDICAL SOCIETY.
111 NORTH KING ST., HONOLULU, HAWAII 96817

law which went into effect Sept. I. The law requires physicians to have at least $100,000 worth of insurance or equivalent assets in order to get a license and also requires contributions to a state compensation fund, thus compounding our malpractice insurance costs instead of reducing it . . .

The Sexual Abuse Treatment Center at Kapiolani Hospital, funded by a $200,000 grant from the 1976 Legislature, opened in October. **Ronald Berman** is chairman of the advisory board and **Francis Terada** the gyn consultant . . .

William Kepler of Kahului, Maui is offering A.I. (Artificial insemination) for dairy goats . . . (No! No! He is not offering his own . . .) He collects semen from top pure bred registered dairy goat bucks on the mainland which are frozen in liquid nitrogen and shipped to him for storage . . . Bill says, "I know its a little out of my line, but I'm hooked on goats and like anyone else who keeps goats, I got frustrated by the lack of available good bucks to use for breeding."

Advertiser columnist George Daacon item: "Our leader, Buck Buchwach, was released from Queen's yesterday after an operation involving 7 coronary bypasses. **Dr. Richard Mamiya** said it was almost a record . . . he once did eight on a single patient."

Another Daacon item: "Local **Dr. Jack Scaff** maintains 'left handers are basically superior people'. Natch, Scaff is a lefty and you can tell by his Parker 45 pen . . . Or didn't you know that ball points smear for left handers so anytime you see someone using a 'real' pen, he is probably a south paw."

Professional Moves

Homo Sapiens Medicus in this The Year of the Dragon pussyfooted at first, but once he got started, he really moved and is still moving . . . In August, **Michael Hase** moved to the Kahala Professional Building, Suite 101 and cardiologist **Vincent Friedewald Jr.** joined the Honolulu Medical Group.

In September, Kona physician **Thomas Mar** and Hilo physician **John Jenkin** both retired from medical practice blaming the new malpractice insurance law. Cardiologist **Coolidge Wakai** went solo and relocated to the Professional Center Building Annex, Suite 435; pediatrician **Martia Angleton** relocated to the Kailua Medical Arts Building at 407 Uluniu Street; and psychiatrist **Kerry Monick,** psychotherapist **Vincent O'Neill** and hypnotherapist **Carl Weisbred** opened their psychiatric and counseling Associates office at 1314 So. King St. . . .

Into Late October . . . pediatrician **Franklin S. H. Young** relocated to 1319 Punahou Street, Suite 1060 (Kapiolani Hospital Building); psychiatrist **Anthony S.Y. Seto** opened at 23 So. Vineyard Blvd., Room 305; and GP-pathologist **Fay Weinstein** opened her office at Kahuku Community Hospital. On the Big Island, **Bill Palmer** announced the association of physician's assistant **Eugenge Hal Caster; Tokuso Taniguchi** resumed his practice at 97 Haili St. and radiologist **Stuart Spielman** associated with the Kona Coast Medical Group . . .

Then in November, OB man **Francis Terada** relocated to Kapiolani Children's Medical Center, Suite 920; and **Ronald Fessenden** opened at Christian Counseling and Medical Center in Aiea. On the Big Island, The Kona Medical Associates announced that surgeon **Gunars Medins** and GP **George Heitzman** have joined them and that their offices will be at the Mar Building in Kailua-Kona . . .

Miscellany

The American History class had two eager Italian immigrants . . . The teacher asked, "Who can recite famous quotations from American history?" Antonio Giolitti promptly raised his hand up high: "I have but one life to give my country! Nathan Hale, 1776." "That's marvelous, Antonio," murmured the teacher gratefully . . . Next Luigi Luzatti raised his hand and proudly recited: "Give me liberty or give me death!" Patrick Henry, Richmond, Virginia, 1775." "How about some of you native born Americans?" harassed the teacher . . . From back of the room, loud and clear, came: "Screw the Guineas!" The teach searched angrily for the culprit . . . "Who said that?" Came the sardonic reply: "General George Patton, Anzio Beach, 1943." (As told by our favorite wit, Walter Young)

Honolulu Orthopedic Supply, Inc.

ORTHOTICS

PROSTHETICS

MASTECTOMY FITTINGS

WHEELCHAIRS

PATIENT AIDS

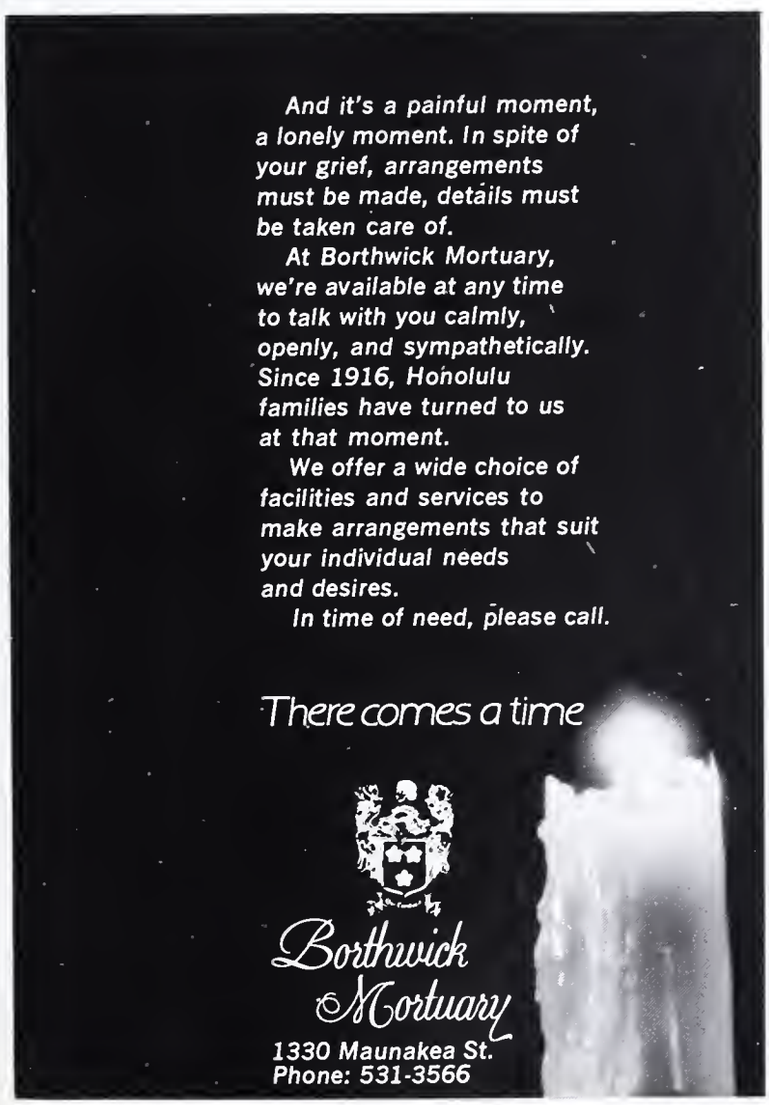
536-6661

1365 Nuuanu Avenue • Honolulu, Hawaii 96817

Hors de Combat

News of continued ferment emanates from our once quiet Kona community . . . As of November, the issue of the Kona Hospital administrator Kenji Nagao had not been settled . . . There is continued newsmedia dialogue between the Health Department and the hospital chief of staff **Frank Ferran.** In October, Honolulu Circuit judge Norito Kawakami refused to dismiss a suit against Nagao by 11 Kona physicians and the trial date was set for Dec. 6. Kona physician **James Mayer** was awarded $1,000 punitive damages on Oct. 7 by a circuit court jury in his $750,000 slander suit against fellow Kona physician **Thomas Mar.** Thomas retired earlier this year claiming the slander suit made it impossible for him to obtain malpractice insurance at a reasonable rate . . . (It seems to us that everyone gets hurt and nothing is really achieved by continued controversy . . . Just a thought . . .)

We do find noxious the HEW release of the names of 2,500 doctors, dentists, labs and pharmacies receiving more than $100,000 for Medicaid services in 1975. It is an obvious attempt by HEW to embarrass or intimidate the recipients . . . Waianae physician **Robert Edwards** and a Waianae dentist Neal Timon both received over $140,000. (We can never begrudge any professional who is willing to accept so many Medicaid patients and who are willing to put in so many working hours . . . The information merely substantiates the fact that Waianae is a depressed area and that few physicians are willing to go out there . . . We did find some comfort in the *Advertisr* editorial stating that Hawaii seems to be free from the so called "Medicaid Mills" that plague some of the more populous states. Also local Medicaid administrator Robert Millar stated tha he ws unworried about fraud here in the Islands . . .)



The AMA News warns that physicians "going bare" are risking financial ruin. Of physicians surveyed, 35% were thinking of dropping malpractice coverage and 13% said they were currently going bare . . .

City medical examiner **Alvin Majoska** has filed a $300,000 libel suit against the *Honolulu Star Bulletin* and Willis Butler . . . Willis wrote two letters about the case of Fitisemanua Moe who died in May after being subdued by police and the *Star Bulletin* had printed those letters . . .

The AMA reported that each visit to the doctor in 1975 cost the average American $1.24 for medical malpractice, an increase of 313% over the average of 2 years ago. The cost of protecting a doctor by his patients is 8.1% of the total cost of the office visit. In 1973, the patient paid 30¢ or 2.4% of the doctor bill to cover insurance costs . . .

A bumper sign on a baby blue Cadillac ahead of us caught our eye: "Support your local trial lawyers—Send your child to medical school," it read in bold black letters . . . When we overtook the Cad, we recognized Jim Marnie, our sometimes vitriolic wit . . .

Miscellany

Three eager golfers arrived at the Makaha West course in their convertible . . . Pacheko, the driver inadvertantly slammed his door shut with the keys in the ignition . . . They tried desperately to open the locked door to no avail . . . Souza suggested they at least get the trunk door open so they can get their golf clubs and play a round . . . The trunk door also resisted their combined efforts . . . Espinda haply looked up at the looming dark clouds and urged, "Say guys!" We better hurry . . . It looks like rain and we got the top down! (A **Charley Cachero** joke as told by **Bill Dang)**

Three Maui surgeons, playing golf on the Wailea GCC were discussing surgery as usual because that's all they know . . . The first surgeon said, "I think artists are the easiest to operate on because their parts are color coded . . ." The second surgeon disagreed, "No, the architects are easier since their parts are numbered . . ." "You guys are all wet!" declared the 3rd surgeon, "The lawyers are the easiest bunch to operate . . . They have only two parts, a mouth and an okole and these parts are interchangeable." (Sent in by a Maui physician)

Elected, Appointed, & Honored

We congratulate **Cal Sia** for his election as president of the HMA and also wish to congratulate **Bill Dang**, outgoing president for a job well done. New officers, if you haven't kept up, are: **Marion Hanlon**, president elect, **Douglas Bell II**, secretary replacing **Varian Sloan**, (who has served efficiently and capably all these years and is finally retiring as permanent secretary) and **Grover Batten**, treasurer. **Herbert Chinn** and **George Mills** are AMA delegates and **Bill Dang** and **William Iaconetti** are alternates. Councillors elected are **Peter Kim** from Kauai and from Oahu, **Calvin Kam, John Edwards, Roland Lichter** and **Arnold Siemson** . . .

And our congratulations to **Livingston Wong** on being named HMA Physician of the Year. Livingston is responsible for the dramatic improvement in our emergency medical services. Livingston, in his quiet, unassuming way has founded the Institute of Renal Services at St. Francis Hosp. in 1970, is chief surgeon of the renal transplant team, and chief of surgery at SFH. He is secretary-treasurer of the Makana Foundation and a member of the National Arthritis, Metabolism and Digestive Diseases Advisory Council of the NIH . . .

On the cancer front: **Reginald Ho** was elected the new president of the Hawaii Division replacing **Drake Will** who will be national professional delegate. Mauian **Alice Broadhurst** was elected director at large of the Hawaii Division . . . **George Bracker** of Hilo was presented a national division award . . . The Maui Unit chaired by **Sakae Uehara** was honored for the 3rd straight year for reaching the highest per capita giving in Hawaii Division.

On the heart front: **Morton Berk** was elected president of the Asian-Pacific Society of Cardiology (APSC) at its 6th Congress held here in October. Also elected were **James Orbison** as secretary-treasurer. The APSC included 17 scientific cardiology societies and 18 countries in the Pacific and in Asia. It will hold its next congress at Bangkok, Thailand in 1979.

Pediatrician **W.T. Chock** was appointed by Mayor Fasi to the City Planning Commission . . . OB man **Frank Hulbutt** replaces **Dick Williams** as medical director of Hawaii Planned Parenthood . . . **Francis Au** was elected president of the Hawaii Chinese Cultural Association at its annual meeting at the Sheraton Waikiki in November.

Pathologists **Grant Stemmerman** and **Takuji Hayashi** of Kuakini Medical Center presented papers (on gastric and colon cancer respectively) at the 7th Annual International Symposium of the Princess Takamatsu Research Fund in Tokyo in November. The symposium sponsored by the Japanese government gathers a small distinguished group of international scientists who have made significant contributions to cancer research . . . Also honored recently was **Kazuo Miyamoto** who recently journeyed to Japan to receive the 4th Order of the Sacred Treasure . . .

Oncology Dialogue

A 73-year old Japanese man who several years ago had surgery for colon Ca and received 5FU therapy was reexplored for obstructive symptoms . . . Surgeon **Roy Tanoue** described his dismal findings: "It was like BB shot or rather cannon balls studding the liver and the omentum." Pathologist **Grant Stemmerman** looked around hopefully and commented: "5 or 10 years ago, this case would not have been worthy of presentation." Surgeon **Francis Oda** declined further comment with: "It's a hard act to follow." Radiotherapist **Carl Boyer** looked askance: "I was hoping the chemotherapists could offer something." Chemotherapist **Quint Uy** said: "I was just about to leave." But Grant pursued the issue with "Guess, there are no new magic drugs?" Quint, cornered, offered: "The only new therapy for Colon Ca is methyl CCNU with BCG," but didn't look too optimistic . . .

Sportsmen's Night

After the delightful dinner of steak and prawns (a Mid Pac CC special), MC **Andy Morgan** drawled a nonchalant welcome with a smoking cigarette dangling in his left hand and his right hand constantly scratching his right axilla . . . He first introduced **John Budde**, president-elect of AMA, a warm, pleasant individual . . . Then Andy drew cheers for retiring executive secretary **Tom Thorson** who "may be back only to check on his property on the Big Island." When Andy thanked HMA president **Bill Dang** for arranging the dinner, there were mixed hurrah's and envious boo's . . .

Skin diver **Bill Moore**, first on the agenda, reported on the Annual Skin Diving Tournament on Kalaupapa. Bill described Kalaupapa as "a distinct subculture with one of its outstanding characteristics being that water is used mostly for bathing and beer for drinking . . . Two new members were added this year, viz **Richard Tessoro** who develops fins and gills when he enters the water . . . and who was voted the champ . . . A close second was the other new member, **Gene Kawaguchi** . . . **Roger Ogata** has developed into a promising spin fisherman and caught two good sized papio . . . We thank **Ted Tseu** for the menu . . . ie, plenty of beer and steaks . . ." The other skin divers included **Herb Uemura, Marc Schlacter, Vic HayRoe** and **H. Yokoyama** . . .

MC **Andy Morgan** describing his Deep Sea Fishing Tournament . . . Only seven die hards had signed up whereas in previous years there were usually over 30 entrees . . . The rough waters had scared others off . . . "We used two boats, viz, **Jim Marnie's** and mine . . . and we went to Molokai and back. Enroute **Roy Kuboyama** spotted a huge glass ball with barnacles which he gets as a consolation prize . . . **Paul Sunahara** got a 18 lb. mahi mahi and **Phil Corboy** a 30 lb. ono . . . **John Peyton** won the perpetual trophy and a silver salad bowl for his 161 lb (dehydrated weight) marlin . . . **Dane Lesser** got a kawa kawa, but we did not hear about **Gene Matsuyama's** catch . . .

Tennis tournament chairman **Virgil Jobe** awarded trophies to Singles Champ **Gene Doo** and to runner up **Ben Chang.** Gene won after a grueling 6-4; 4-6; 6-2 match at Beretania Courts with Gene having to call time out when he developed severe leg cramps in the last set . . . Consolation bracket winners were **Dennis Maehara** with runner up **Leabert Fernendez** . . . The doubles champ were the unbeatable duo of **Leabert Fernendez** and **Yutaka Yoshida** (ages 65 and 64 respectively, for a combined age total of 129 years) who seem to improve with age like good wine . . . Second place was the duo of **Gene Doo** and **Cal Sia** and in 3rd place were **Worldster Lee** and **Kenneth Kern** . . . The doubles tournament was a social event with 21 odd teams signed up and 3 courts available, all matches to be played in one Saturday afternoon . . . Luckily Yutaka Yoshida had the foresight to see that a round robin match with 21 teams, even at 4 games apiece could never be finished and he suggested that the teams be assigned to 3 flights and that the round robin be within the flights. Then the 3 flight winning teams could playoff . . .

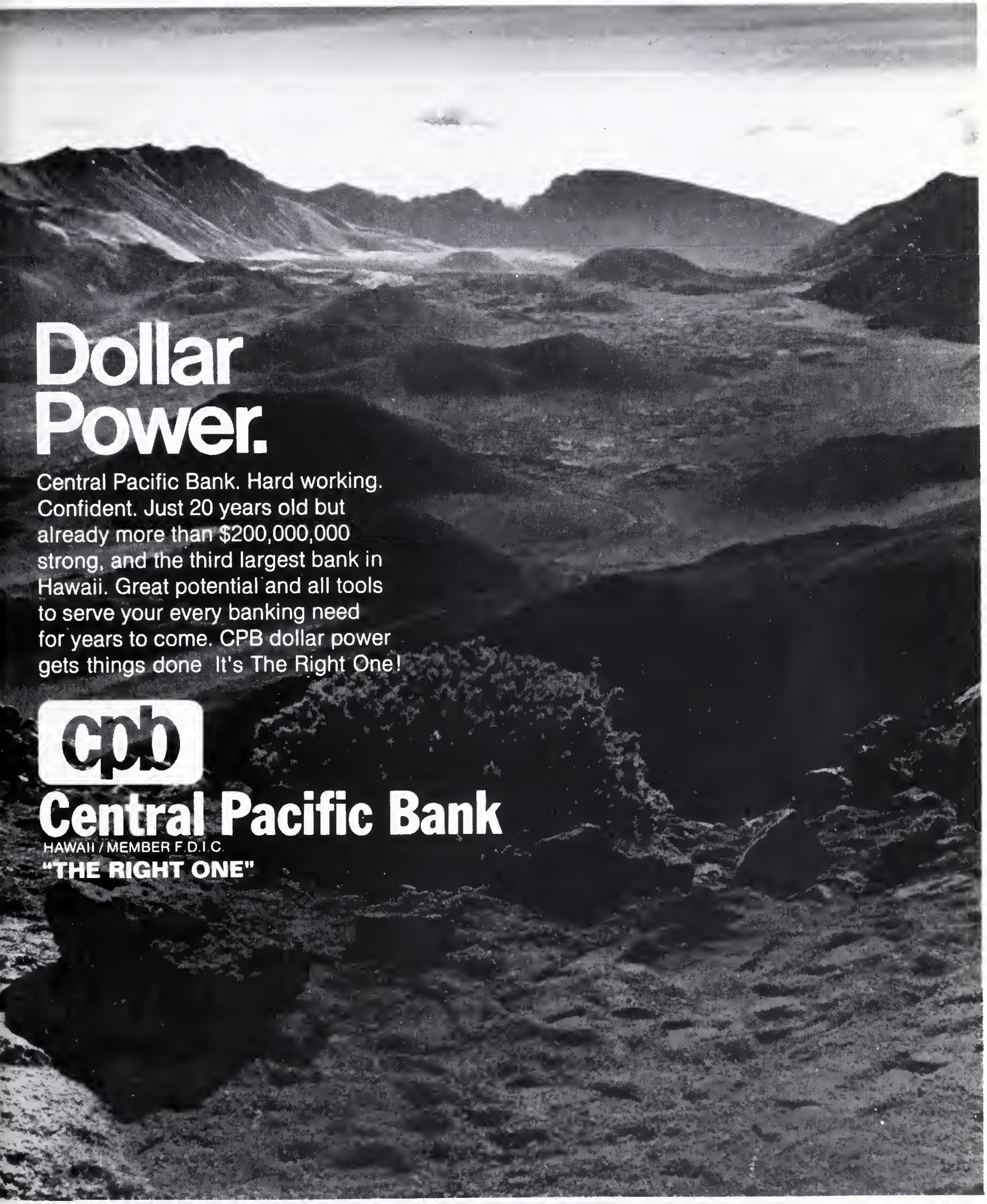
Franklin Young chaired the first annual ping pong doubles tournament with 8 doubles teams entered. Franklin donated a perpetual torphy which was won by OB men **Phil McNamee** and **John Spangler** with "their smooth deliveries." In second were the team of **Joe Young** and **Franklin Young. Al Buster Richardson** and **Cyrus Loo** were 3rd while **Alex Roth** and **Franklin Lu** were 4th. The other participants were **Worldster Lee** and **Herbert Young, Don Char** and **Noni Kock Brar,**

Is the diagnosis ALCOHOLISM?

Time proven alcoholism treatment — formerly available only at Mainland centers — now offered at Post Hospital Recovery Unit, Hilo Care Center.

- A basic, 28-day in-patient program of motivational counseling
- Therapists carefully selected and themselves recovered alcoholics
- Hawaii licensed professional consulting staff in psychiatry, psychology and family medicine
- Privacy, seclusion, total confidentiality in modern facility, beautiful setting

Direct inquiries to:
Marilee Fletcher, Associate Director,
Post Hospital Recovery Unit,
HILO CARE CENTER
944 West Kawailani Street
Hilo, Hawaii 96720 Phone (Hilo) 959-9151


Dollar
Power.
Central Pacific Bank. Hard working. Confident. Just 20 years old but already more than $200,000,000 strong, and the third largest bank in Hawaii. Great potential and all tools to serve your every banking need for years to come. CPB dollar power gets things done It's The Right One!
cpb
Central Pacific Bank
HAWAII / MEMBER F.D.I.C.
"THE RIGHT ONE"

OWN A PIECE OF THE STRIP!

JOCKEY CLUB

IN LAS VEGAS

Las Vegas' most beautiful condominium resort on the Strip next to the Dunes—across the street from the MGM and the Aladdin Hotel.

Compare your pluses:

Tax shelter
Maximum profit potential
No recession on the Strip

Fortunes are made by being at the right place at the right time. COMPARE this investment with any condominium in Hawaii. *There are over 12,000 unsold units.* (1976 Bank of Hawaii report)

Now is the time to get in on the ground floor before the Jockey Club Casino opens! Single and Hui purchases welcome.

One Bedroom Suites from $52,000

CENTURY PACIFIC, INC.
REALTORS

1027 A Bishop St. Honolulu
Ph. 521-6987

Hiro Tottori, and **Dennis Maehara** and **Ghim Yeoh** and son . . .

Bill Dang and **Ernesto Orinion** were co-chairmen of the Golf Tournament, by virtue of having won last year's tournament . . . Low gross winner was **Mike Okihiro** with a gross 78. Low net winner again was **Bill Dang** with net 66 (84-18-66); **Herb Takaki** with net 68 was 2nd, tied at 3rd place were **LT Chun**, **C.M. Lum** and **Garth Morimoto** with net 69's. At net 70's were **Ed Izawa** and **Allan Young**; at net 71's were **Mike Piel**, **Glen Kokame** and **Henry Fong**; at net 72's were **Ed Kagihara**, **Mike Okihiro**, **Winfred Hang**, **Ike Nadamoto**, **Al Chun Hoon**, at net 73's were **Henry Yim**, **Ross Hagino**, **Ernesto Orinion**, **Dick Lam**, and **Dick Omura.** At net 74's were **Al Paraz**, **Bob Kim**, **Al Ho**, **Charley Cachero**; at net 75's were **Torres**, **Don Maruyama**, at net 76 was **Dick Ho** all alone, at net 77 were **Varian Sloan**, **David Sakuda**, **Norman Nakamura**, **Fred Lam**; at net 78 were **Richard Mitsunaga**, **Nobu Nakasone**, **S. Ogawa**, **Y. Fukushima** and **Cliff Chang.** At net 81 was **Bob Oishi**, at net 83 **Paul Lin**, at net 86 was **Peter Kim** and at net 87 **Raymond Wong.** High Gross was won by **Henry Manayan** . . .

During the awarding of prizes, senior golfer Al Ho suggested that there be a senior HMA tournament as well and a Senior Perpetual Trophy which he will donate.

The first annual HMA County Team Championship was won by the Honolulu team of **C.M. Lum** and **Charley Cachero** which beat the Kauai county team of **Peter Kim** and **Bill Dang** (surrogate partner). The Tom Thorson Perpetual Trophy for this Intercourse Championship was donated to the winners by Tom Thorson . . .

Dream (Letter to the editor, *Honolulu Star Bulletin*, June 9 issue, by **Fred Reppun**, our favorite author and chairman of Neighborhood Board No. 29)

"I had a dream.

I dreamed that Joe Pao accompanied me to the gates of St. Peter and I stood and watched as St. Peter gently rebuked Joe for all the scars he had made on the paradise on earth that was Oahu, particularly the one in beautiful Manoa and the other on the slopes of Olomana overlooking Kailua.

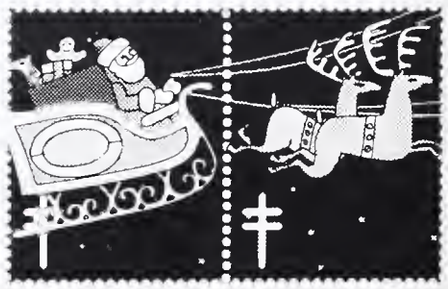
But then, St. Peter forgave him these sins, and even the one that produced the urban sprawl that is Enchanted Lakes, and St. Peter led him through the gates and into Heaven, leaving me to stand alone, outside, and wondering.

I awoke, remembering the dream, puzzled, then dozed off again. Surprisingly, I dreamed again, a recurring one. St. Peter appeared again. Joe Pao was beside him, clad in ethereal raiment.

St. Peter noticed, and responded to my look: "You left Earth too soon to hear the latest broadcast. Joe's last eathly act was to spend his entire fortune to acquire Waiahole/Waikane in fee, all 2,900 acres of that earthly paradise. And he dedicated it to the tenants and farmers who were still residing there, still resisting evictions, nonviolently, and Joe Pao granted all of them perpetual tenancy, to them and to their progeny, but only to farm and to pay a tax to a reasonable government—NOT the highest, but the BEST use, as a tax basis."

I awoke, fully this time. Except for the dream, our last Neighborhood Board meeting had been rather dull." ■

Christmas Seals
Fight Lung Disease



Space contributed by the publisher as a public service

Your investments demand constant attention.



Can you provide it?

Investing is easy. Smart investing is tough. We've gone through decades of investing and we've proven that it takes more than just money to make money. It takes expertise, hard work, a personal concern . . . and time.

Our investment officers are in constant contact with other specialists and investment researchers here and abroad, all day, every day. They use every resource to maximize opportunities and minimize risks. And because of that, we've grown to be Hawaii's largest trust company with Hawaii's largest investment department.

Hawaiian Trust represents more than 2,800 accounts of all sizes. Our Investment Department consists of more than 20 people, all of them with their own specific area of expertise, to insure that you benefit from in-depth as well as broad-based knowledge. They'll give you the service you need. That's why we've been able to deliver strong, solid growth in capital and income for our clients over the years.

Can you afford the time, the worry and the risks of potential losses? A lot of people can't. We work for them. And only for them.

Trust Hawaiian.
Hawaiian Trust Company, Ltd.

Financial Plaza of the Pacific • P.O. Box 3170 • Honolulu, Hi. 96802 • 525-8511
Wailuku Town House • Wailuku, Maui 96793 • 244-7965
120 Pauahi Street • Hilo, Hi. 96720 • 961-3784

Letters *continued from 359*

To The Editor:

This is a response to Dr. Alan Pavel's letter in the October 1976 HAWAII MEDICAL JOURNAL. Rather than creating a schism in the HMA and possibly injuring the feelings of well respected colleagues, we wish to make it clear that we commend all those who are seeking solutions to the malpractice problem and we feel that none of us who hold a particular position or philosophy should expect everyone else to accept it. The option which we are providing should be given consideration equal to the traditional one as well as other options such as the C.A.P. (Cooperative) arrangement advocated by some. Since Dr. Pavel's letter was addressed to all HMA members and made particular mention of HPPA it is only proper that you should have our remarks as well.

Neither HPPA nor its program is an exclusive creature of Dr. Claude Caver. We are incorporated as a professional society and all our actions are the product of our elected Board of Directors. We cannot in any way be construed as an "insurance company" with "policy holders." Our charter is specifically structured to avoid our being classified as an insurance provider, for we would then be back under the Department of Regulatory Agencies' other hat.

Traditional professional liability insurance has both a protective aspect—the means to defend against legal actions—and an aspect that attracts such action, namely a fund for payment of awards. The protective aspect is partly cancelled out by the tendency of the insurance company to nudge, gently or otherwise, the insured into settling out of court. HPPA seeks to keep the protective aspect intact and not to include the negating feature of a fund to pay awards. Traditional insurance has not only failed for both the insurer and the insured but has gradually brought about the present situation of ever increasing suits, judgements, and premiums. To those who believe the insurance profits are excessive the idea of physician ownership is appealing, but the fact is that the insurance carriers are all losing money and trying to abandon the field. If they are losing money why should physicians also want to lose money in their own company?

Thus, while the insurance concept is clearly sinking, the protective concept has been a demonstrated success for a hundred years in Britain and Canada. Real protection such as our Legal Defense Fund is a credible deterrent to suit, very similar to our ICBM silo system. As long as you have got it you will never have to use it. Perhaps there are indeed those who would attack a well armed group but they are very few, so few that protection probably decreases the likelihood of lawsuit by at least twenty to one. No reasonable contingent-fee attorney or fee-paying client will spend years of time and up to fifty thousand dollars of his own money if there is no ready source of cash to pay a judgement and when 87% of those suits are won by the defendant. In addition a prepaid legal defense evens the odds between plaintiff and defendant since neither has to pay anything.

We have never advocated that a physician "hide" his assets but that they be protected by simple and legal means which were legislated just for that purpose. The laws in Hawaii are heavily stacked in favor of defendants in all sorts of legal actions. Reading these laws would give Dr. Pavel and others much comfort. One does not have to give away his assets and become a pauper; simple conversion of ownership of all property, bank accounts, securities and chattels to "tenancy by the entirety with full right of survivorship" makes them immune to attachment except for unpaid taxes. Accounts receivable are immune until collected and no action would be taken against them in any event, because the physician could give his patients a bonus by cancelling them at any time and there would be nothing to attach. A garnishment action granted by a court is good only for one day and is expensive to obtain, requiring a 3% bond for the full amount each time. Those in the know deposit all receipts daily and immediately withdraw them to a joint personal account which cannot be touched. Garnishment of insurance claims is also limited to only those claim checks written on the day of garnishment and if you pick them up early each day there is nothing for garnishment. The scare stories in the *American Medical News* and throw-away journals apply to some mainland states only and no such cases have ever occurred in Hawaii. Strangely, in Hawaii your office equipment can be attached but no attorney wants your stethoscope or your old specula.

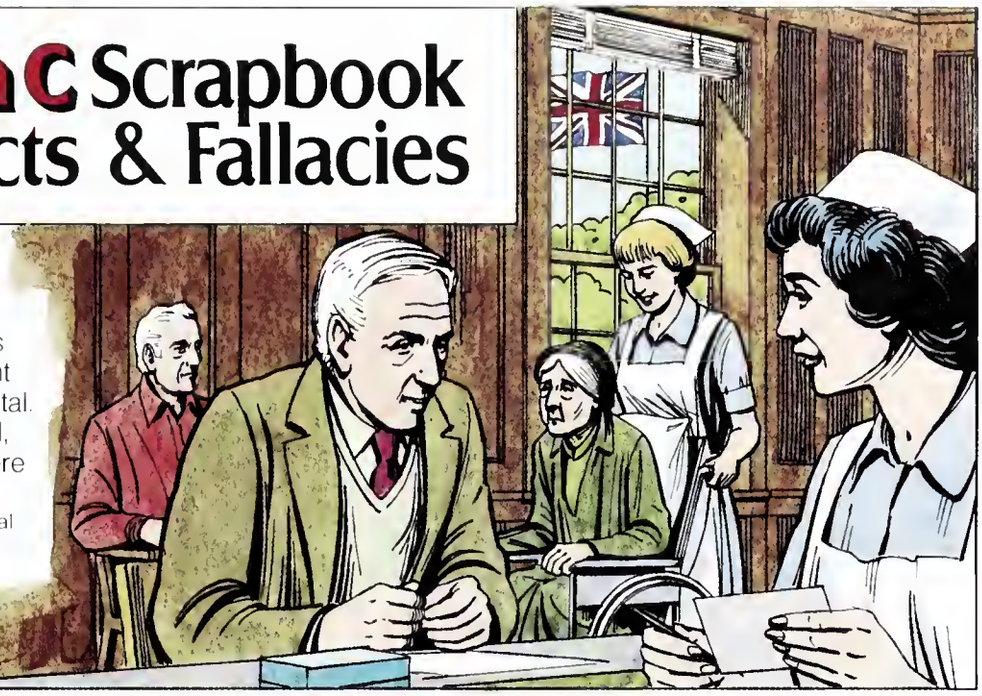
It is our belief that mere cancellation of insurance alone is a very reliable assurance of not being sued but that prepaid legal defense is an additional guarantee. It is not necessary to go elsewhere for examples of this; we have many physicians right here who have never carried insurance and never been sued and most of us are aware of the high-risk neurosurgeon who was sued regularly for thirty years while insured but who has not been sued even once in the 13 years he has 'gone bare.' We certainly have no objection to high-risk physicians buying liability insurance if they wish but they should reflect that it is their high coverage policies which have produced the high premiums, abuses of the legal system, and the adversary atmosphere about which Dr. Pavel complains.

Act 219 cannot simply be described as complex. It is a mish-mash product of many committees and their lawyer chairmen, all trying to exert themselves in a problem area in which there are no experts, only guessers. To go back and wheedle them for amendments could yield a result even worse than before since it is still trading-out operation. Our strategy: **repeal the act to demonstrate our unity and strength, then present our own bill and stand up for it all the way through.**

As for those portions of Act 219 thought to be worth of salvage:

1. Medical Claims Conciliation Panel—the composition of a physician, a lawyer and a judge seems to be the same cast found in the court-room dramas. It is unlikely to serve to prevent frivolous and 'shot-gun' suits or reach any decision of wisdom and impartiality. It is tempting to think this panel would help us but even if it should it would probably be soon restrained or declared unconstitutional (Kansas example) just as we are doing with the "compulsory insurance for licensure" clause. The panel stage will also add to the cost of a case and further impel the insurance carrier to raise premiums and urge settlement. While our legal protection serves as a credible deterrent to frivolous suits the panel feature will tend to encourage them because it will be more disposed to give a little something to each plaintiff. An attorney who persists in a suit after an adverse panel decision will not worry about his

The ALLBEE® with C Scrapbook of Vitamin Facts & Fallacies



A study conducted among elderly patients in England showed that 41% were deficient in ascorbic acid on admission to the hospital. Even among those living at home and well, or not sufficiently ill for admission, 27% were deficient in ascorbic acid.

Griffiths, L.L., Brocklehurst, J C., MacLean, R. et al *Diet in Old Age*, Brit Med J., 1 739, 1966



The loss of riboflavin in milk in a glass container exposed to sunlight for two hours may be as high as 95%.



Quick freezing of vegetables is accompanied by very little ascorbic acid loss. But blanching, washing, and prolonged standing at room temperatures results in considerable reduction in Vitamin C content.

In World War I a unit of 100 beds per division in the Russian army was set aside for scurvy patients. Yet, only 20 cases of scurvy were reported among all American troops in 1917-18.





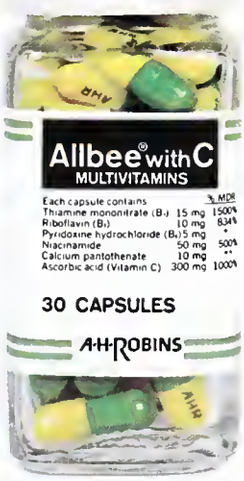
At least 144 different quality assurance tests are run on the raw materials and manufacturing steps that go into Allbee® with C. The Monogram "AHR" on every capsule is your assurance that this is the original and genuine Allbee® with C and not an imitation.



Available on your prescription or recommendation

ALLBEE® with C

High Potency B-Complex and Vitamin C Formula



A.H. Robins Company, Richmond, Va. 23220 A·H·ROBINS



Spasm reactor?

Donnatal®!

	each tablet, capsule or 5 ml tsp of elixir (23% alcohol)	each Donnatal No. 2 Tablet
Phenobarbital (warning: may be habit forming)	(¼ gr) 16.2 mg	(½ gr) 32.4 mg
Hyoscyamine sulfate	0.1037 mg	0.1037 mg
Atropine sulfate	0.0194 mg	0.0194 mg
Hyoscine hydrobromide	0.0065 mg	0.0065 mg

Indications: Based on a review of this drug by the NAS/NRC and/or other information, FDA has classified the following indications as possibly effective: adjunctive therapy in the treatment of peptic ulcer; the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis. Final classification of the less-than-effective indications requires further investigation.

Brief summary. Contraindicated in patients with glaucoma, renal or hepatic disease, obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy) or a hypersensitivity to any of the ingredients. Blurred vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur at higher dosage levels, rarely at the usual dosage..

A·H·ROBINS A. H. Robins Company Richmond, Virginia 23220

Let us help plan your estate FREE.



Estate planning isn't the easiest thing in the world. It should be in the hands of professionals. Like your accountant, your insurance agent, your attorney. And a First Hawaiian Bank trust officer.

Fact: First Hawaiian is the *only* full service trust bank in Hawaii.

One of our trust officers will be happy to meet with you. He'll review your present situation. And ask for your thoughts and goals. Then we'll tailor an estate plan to your specific needs. At no charge.

Your Customer Consultant can arrange an appointment for you. Or call Joe Battista, Ken Nakamura or Herb Loomis in our Trust Division at 525-7051.

First Hawaiian Bank

the bank that says yes

MEMBER FDIC

client suing him, after all *he* carries malpractice insurance.

2. *Patients Compensation Fund*–this is to be built up by premium assessments, now set at 30% per year, however, at any level of growth of the fund one large judgement could wipe it out and the assessments would begin again. Thus assessments could be made several times a year and at an even higher percentage. There is no reason to believe this will not happen because the existence of this "pot of gold" will increase the number of amount of suits over the present level of $100,000.00 insurance. If several suits over one million have been filed in the past we can certainly expect many more larger ones when this fund is available. In the past attorneys have sued for inflated amounts as a tactic to pressure for a quicker and larger settlement. With this fund available attorneys will sue for inflated amounts in hope of getting an actual judgement for the amount claimed. Finally, the compulsory contributions to this fund are even more objectionable than the compulsory insurance itself since the fund pays for no legal costs or settlements, only awards.

3. *Informed consent*–this clause bears some hope of solving this aspect of the problem but we can certainly look forward to court tests of any definitions or consent forms devised. Even if the effort is successful it would not help much in Hawaii, since by Dr. Pavel's own statement before the HMA House of Delegates lawsuits based on lack of informed consent have not been a problem here. We shall see.

It is useless to recite the many bad features of Act 219 such as the reporting feature which would subvert or destroy all peer review in the state, or the preamble which implies that the malpractice crisis is caused by a rapid deterioration in physician and hospital performance. Among all the bad features only three have been cited as worthy of salvage. After World War II Herman Goering is reputed to have said that the Allies should not condemn a whole system because of a few faults.

Neither repeal nor amendment of Act 219 is personally important to the members of HPPA because we are ignoring the Act. We will do nothing to obstruct amendments but we feel that this route is a legislative minefield and will be a long uphill struggle. We prefer repeal because we fear that the medical profession will be enticed to drift into the same political deals which entrapped them in England. Instead of compromising with opponents we choose to make aggression a bitter course and fight like Hell.

This letter seemed indicated by Dr. Pavel's comments on the leadership and nature of the HPPA and its efforts. It is not intended to deprecate Dr. Pavel's considerable efforts in unravelling this knotty problem. We hope his faith that premium rates will fall proves justified. In the meantime, while they are still rising, we feel that we cannot hold our breaths until a mechanism is created or costs come down. We go bare.

CLAUDE V. CAVER, M.D., *President HPPA*
JOHN C. ROBERTS, M.D., *Vice-President*
THEODORE TSEU, M.D., *Secretary*
ALVIN MAJOSKA, M.D., *Treasurer*

To The Editor:

We would be grateful if you can run the following appeal as a letter to the editor. If you cannot do so, please let me know the cost of running it as an ad set one column bold face boxed:

"For a biography of Dr. Alton Ochsner of Ochsner Clinic, New Orleans, opinions, evaluations, anecdotes, reminiscences, photos are needed. Photos will be carefully handled and returned. All material gratefully received by

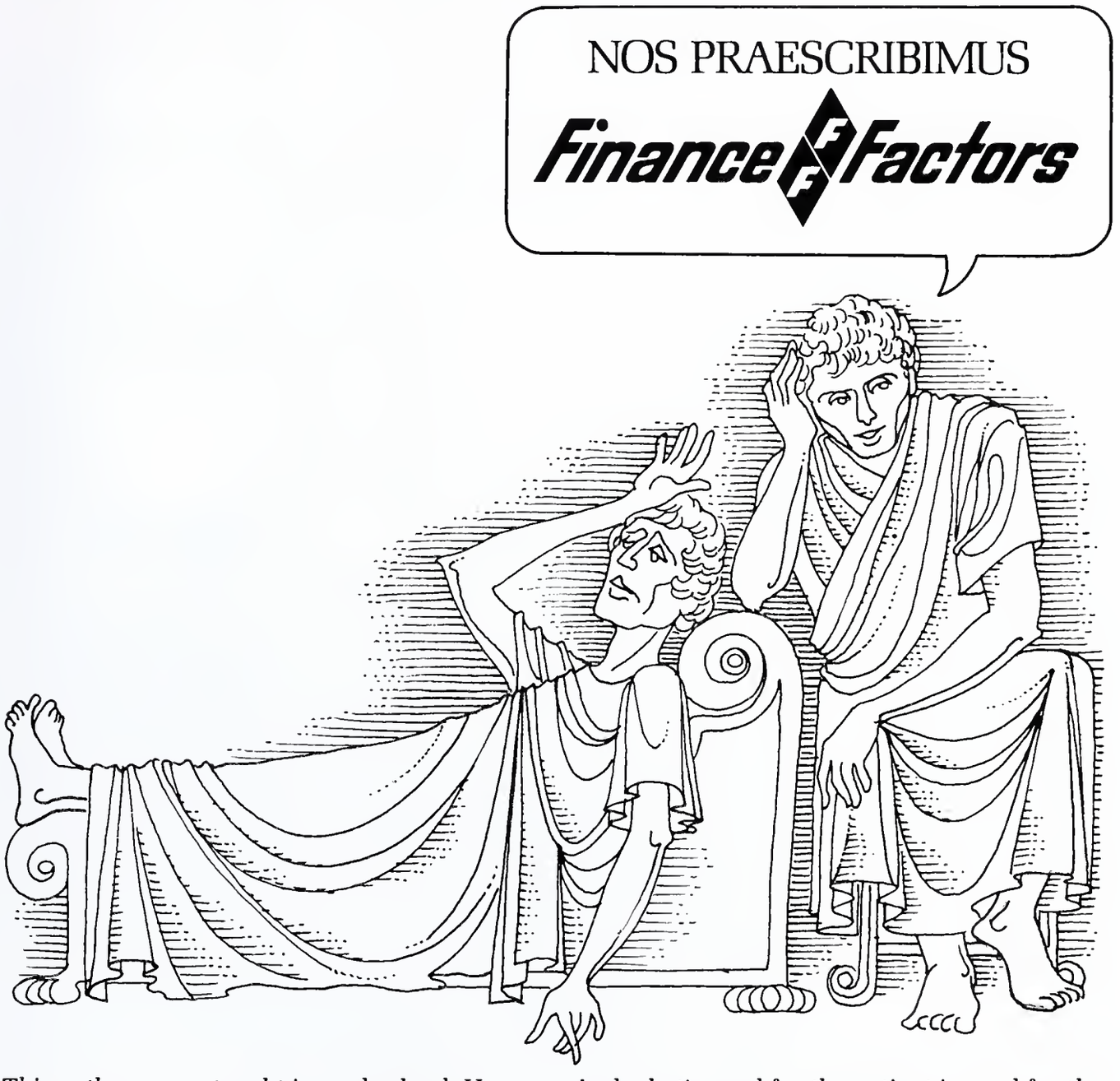
Sincerely yours,

Ira Harkey, PhD
401 Metairie Road, 706
Metairie, Louisiana 70005"

"Our Angels"

	Page
Aina Haina Professional Building	371
Borthwick Mortuary	417
Bureau of Medical Economics	415
Central Pacific Bank	419
Century Pacific, Inc. *Jockey Club*	420
First Hawaiian Bank	425
Finance Factors	427
Hawaii Medical Service Association	432
Hawaiian Trust Company, Ltd.	421
Hilo Care Center	418
Honolulu Orthopedic Supply, Inc.	416
Eli Lilly and Company	362
C.R. Newton Co., Ltd.	414
Lydia O'Leary of Hawaii *Covermark*	415
Pathology Associates Medical Laboratories	358
Pharmaceutical Manufacturers Association	428, 429
A.H. Robins Company *Allbee/Donnatal*	Insert 423, 424
Roche Laboratories *Dalmane*	430, 431
Valium	356, 357
Roerig *Atarax*	360, 361

INFIRMITAS PECUNIAE?



Things they never taught in med school. How to write a prescription for Financial Woes. But it happened then, and it happens today. The old chariot breaks down. The kids want to see the big one at the Coliseum. The columns on your house are Doric, but now the wife wants Ionic. Creditors and the tax collector must be paid the Denarii due them. Et Cetera. The cure for the infirmity is simple: Negotiori Pecuniariae. Today we call it Finance Factors.

And what's good for the patient is good for the healer too. Before the sundial has recorded the passage of a single day, you can complete a loan application and borrow up to $10,000. Send a messenger — or make a personal call — to Vice President Edmund Leong at Finance Factors' main office, 195 South King Street, or telephone 548-4954. He does general practice, and he's a specialist in personal loans. Everything is confidential, of course.

Treating Infirmitas Pecuniae since MCMLII.


RECENT CHANGES
federal register
Providing Drug Information to Physicians
Informational Bulletin #433-76
National Health Insurance
special report
Malpractice insurance:
drug bulletin
Health care doesn't need more red tape
Drug firms challenge 'MAC' rules
Drug Substitution
RESEARCH
Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



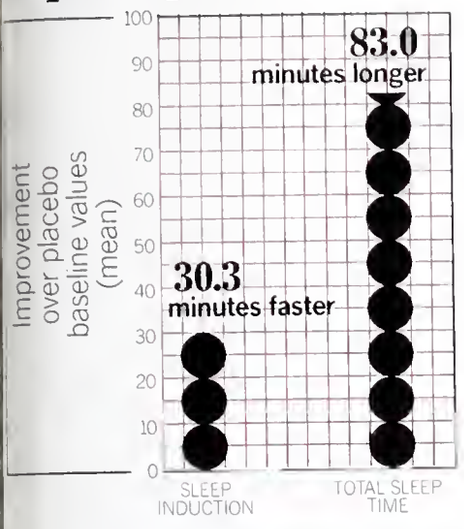
Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

The ultimate objective test: sleep laboratory proof of effectiveness... now in geriatric insomnia patients

Six female insomniacs, ranging in age from 67 to 82 years, received Dalmane (flurazepam HCl) for seven consecutive nights in the sleep research laboratory.[1] Improvement over pre-treatment baseline levels was significant for sleep induction and sleep maintenance ($p < .05$). And the greater the sleep problem in these patients, the better the effect with Dalmane (significant correlation at $p < .01$ level).



Elderly insomniacs fell asleep faster, slept longer[1]



Results expand and confirm objective proof of efficacy in younger adults with insomnia

The effectiveness of Dalmane (flurazepam HCl) was demonstrated in earlier studies of 32 younger adults with trouble falling asleep, staying asleep or sleeping long enough.[2] On average, in these studies, Dalmane induced sleep within 17 minutes and provided 7 to 8 hours of sleep, at the same time reducing number of nighttime awakenings.

Relative safety, even in patients on warfarin

Morning "hang-over" has been relatively infrequent with Dalmane. And no unacceptable fluctuation in prothrombin time has been reported in warfarin patients on Dalmane.[2,3] The usual adult dosage is 30 mg *h.s.*; in elderly and debilitated patients, limit initial dosage to 15 mg to help preclude oversedation, dizziness or ataxia.

Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:
Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.
Contraindications: Known hypersensitivity to flurazepam HCl.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).

***Usage in Pregnancy:* Several studies of minor tranquilizers (chlordiazepoxide, diazepam, and meprobamate) suggest increased risk of congenital malformations during the first trimester of pregnancy. Dalmane, a benzodiazepine, has not been studied adequately to determine whether it may be associated with such an increased risk. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.
Precautions: In elderly and debilitated, limit initial dosage to 15 mg to preclude oversedation, dizziness and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.
Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase.
Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.
Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

REFERENCES:
1. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
2. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
3. Robinson DS, Amidon EL: Interaction of benzodiazepines with warfarin in man, in *The Benzodiazepines*, edited by Garattini S, Mussini E, Randall LO. New York, Raven Press, 1973, p. 641

Objective evidence proves insomnia relief in elderly patients

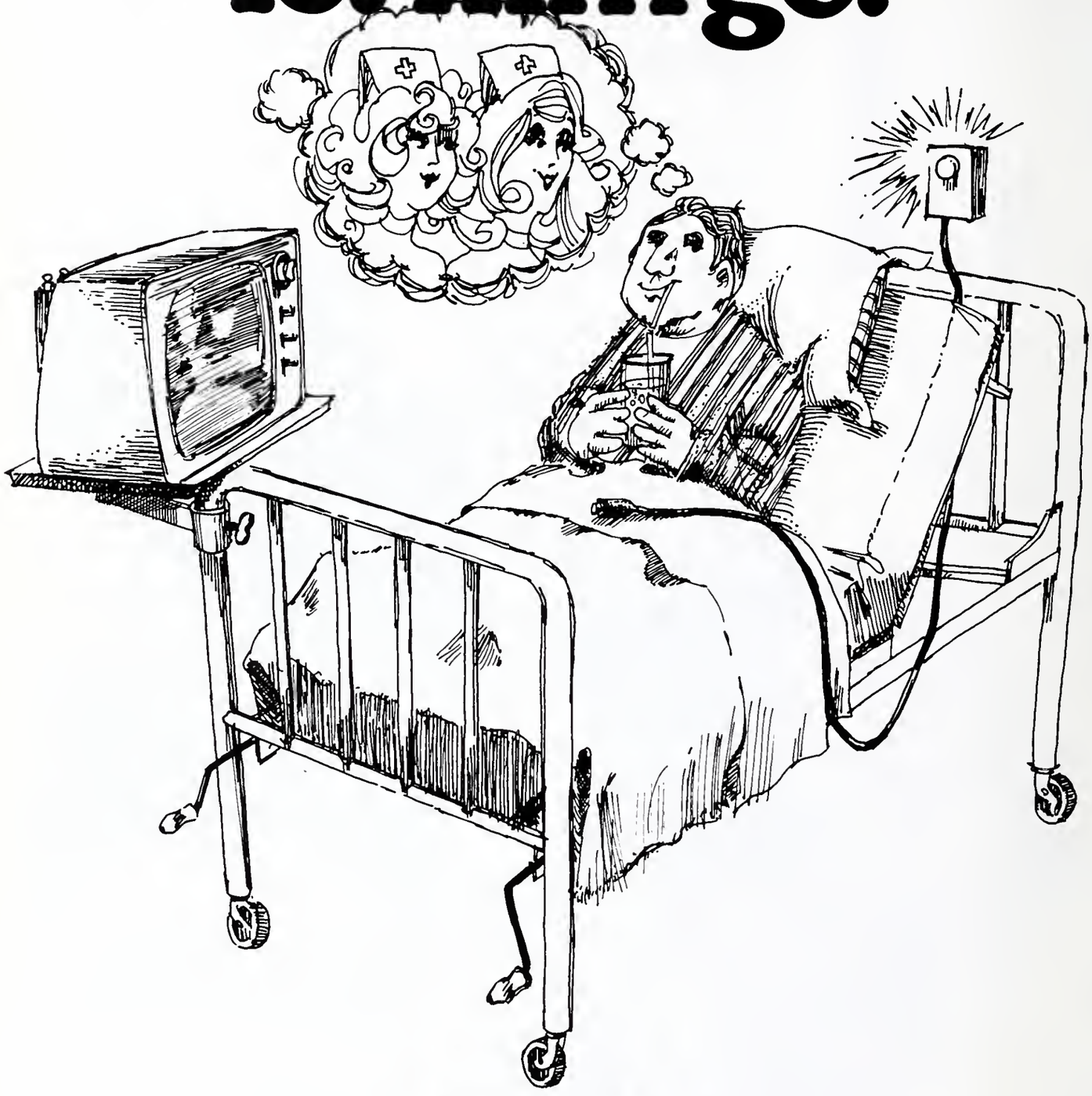
Dalmane®
(flurazepam HCl) ℞ IV

One 15-mg capsule *h.s.*—initial dosage for elderly or debilitated patients.
One 30-mg capsule *h.s.*—usual adult dosage (15 mg may suffice in some patients).

For all common types of insomnia

ROCHE
ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Before he hollers, let him go.



Spare him the discomfort of an extra bundle of hospital bills.

When it's time to discharge a patient, remind him that HMSA can still cover therapy and diagnostic work on an out-patient basis.

It's less expensive, and another way doctors and HMSA can help the people of Hawaii hold down the cost of their medical care.

HMSA®

D1944S

Hawaii Medical Service Association

THE LIBRARY
UNIVERSITY OF CALIFORN A
San Francisco
THIS BOOK IS DUE ON THE LAST DATE STAMPED BELOW

7 DAY LOAN

7 DAY
MAR - 3 1978
RETURNED
FEB 27 1978

15m-6,'73(R176884)4315-A33-9

ST

324773